APPENDIX - VOL. IV

Supreme Court of the United States

OCTOBER TERM, 1974

No. 74-1589

GENERAL ELECTRIC COMPANY,
Petitioner,

v.

MARTHA V. GILBERT,
INTERNATIONAL UNION OF ELECTRICAL, RADIO AND MACHINE WORKERS, AFL-CIO, CLC, *et al.*,
Respondents.

No. 74-1590

MARTHA V. GILBERT,
INTERNATIONAL UNION OF ELECTRICAL, RADIO AND MACHINE WORKERS, AFL-CIO-CLC, *et al.*,
Petitioners,

v.

GENERAL ELECTRIC COMPANY,
Respondent.

ON WRITS OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

PETITIONS FOR CERTIORARI FILED JUNE 17, 1975
CERTIORARI GRANTED OCTOBER 6, 1975

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VOLUME IV

PLAINTIFFS' EXHIBIT NO. 43B

General Electric Insurance Plan–Additional Information 1972, Corporate Accounts and Reporting Operation 3/27/73, received by IUE May 3, 1973.

GENERAL ELECTRIC INSURANCE PLAN ADDITIONAL INFORMATION–1972

May 3, 1973

During the calendar year an average of 311 421 employees had personal coverage, while an average of 219 337 employees also had coverage for their dependents.

The amounts shown on Exhibit I do not reflect the benefits of $2 590 998 paid during the year to pensioners and their spouses and surviving spouses under the General Electric Medical Care Plan for Pensioners.

The amount of $15 733 839 shown on Exhibit I as other charges consists of the following:

Amount set aside to help provide life insurance coverage for pensioners	$16 061 000
Taxes, expenses, adjustments of reserves, and all other purposes	7 064 935
Lee interest credited on reserves	(7 392 096)
	$15 733 839

The incurred claims of $200 667 995 shown on Exhibit I consist of:

Benefits paid directly to or for employees and their beneficiaries	$197 055 563
Increase in reserves to pay claims incurred in one year, but which are not reported until a year later	3 612 432
	$200 667 995

At the end of 1972, the Insurance Companies were holding reserves of $186.6 million to meet Plan obligations.

CORPORATE ACCOUNTING CONSOLIDATION & REPORTING OPERATION
JJP:DEA 3/27/73 EXHIBIT II

GENERAL ELECTRIC INSURANCE PLAN
COST AND PARTICIPATION DATA
CALENDAR YEAR 1972

Summary of Operation	Employee Coverage	Dependent Coverage	Total
Advance Deposits to Insurance Companies			
Life Insurance	$ 45 137 504	$	$ 45 137 504
Accidental Death or Dismemberment	1 381 873		1 381 873
Weekly Sickness and Accident	26 110 217		26 110 217
Medical Expense Insurance	8 114 027	9 432 386	17 546 413
Total Advance Deposits to Insurance Companies	80 743 621	9 432 386	90 176 007
Refund of Excess Deposits	71 489	280 430	351 919
Cost of Plan - Insured Portion	80 672 132	9 151 956	89 824 088
Benefits Provided Directly by the Company	58 641 724	67 936 022	126 577 746
	139 313 856	77 087 978	216 401 834
Net Cost of Plan			
Employee Contributions	137 347	21 400 064	21 537 411
Net Cost to Company	$139 176 509	$ 55 687 914	$194 864 423
Per Cent of Net Cost of Plan Paid by:			
Employees	.1%	27.8%	
Company	99.9	72.2	
Total	100.0%	100.0%	
Participation at December 31, 1972			
Number of Employees Participating	312 837	220 124	
Analysis of Net Cost of Plan			
Incurred Claims			
Life Insurance	$ 33 985 298		$ 33 985 298
Accidental Death or Dismemberment	1 610 018		1 610 018
Weekly Sickness and Accident	25 672 401		25 672 401
Medical Expense Insurance	64 232 375	75 167 903	139 400 278
Total Incurred Claims	$125 500 092	$ 75 167 903	$200 667 995
Commissions paid by Insurance Companies			-0-
Other charges for taxes, expenses, adjustments of reserves and all other purposes			15 733 839
Net Cost of Plan			$216 401 834

CORPORATE ACCOUNTING CONSOLIDATION & REPORTING OPERATION
JJP:DEA 3/27/73

EXHIBIT I

ADDITIONAL INFORMATION – 1972

During the calendar year an average of 311 421 employees had personal coverage, while an average of 219 337 employees also had coverage for their dependents.

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CORPORATE ACCOUNTING CONSOLIDATION & REPORTING OPERATION
JJP:DEA 3/27/73 EXHIBIT II

PLAINTIFFS' EXHIBIT NO. 58

Letter from John Shambo to John Baldwin of GE dated 2/24/72.

NATIONAL GENERAL ELECTRIC CONFERENCE BOARD
of the
International Union of Electrical, Radio and Machine Workers
AFL-CIO
15 East 41st Street
* * * New York, N. Y. 10017 * * *

February 24, 1972

Mr. John Baldwin
Manager of Consulting Services
General Electric Company
570 Lexington Avenue
New York, N.Y. 10022

Dear Mr. Baldwin:

The International Union of Electrical, Radio and Machine Workers, AFL-CIO-CLC, requests that GE agree with the Union to correct the below described provisions in the 1970-1973 GE-IUE (AFL-CIO) National Agreement and General Electric Pension and Insurance Plans. Judged by the present state of court decisions and EEOC guidelines and decisions these provisions discriminate because of sex in violation of Title VII of the Civil Rights Act of 1964 and state legislation against such discrimination which is now in effect in 32 different states, including New York and most of the other states in which the GE-IUE National Agreement is applicable. Because GE is a federal contractor, by reason of the provisions of Section 60-2.21(d)(7), Revised Order No. 4, Affirmative Action Gudieline, GE is required, prior to April 2, 1972, to "review all contractual provisions to ensure that they are non-discriminatory."

* * * * *

With respect to loss of time from work by females due to disabilities arising from pregnancy, miscarriage or childbirth there are several respects in which the 1970-1973 GE IUE National Agreement, the General Electric Insurance Plan and practices thereunder, judged by the principles enumerated in court and EEOC decisions, discriminate unlawfully because of sex. The Court in *Cohen v. Chesterfield County School Board,* 326 F. Supp. 1159, 3 FEP Cases 525 (E.D. Va. 1971) held that it constituted unlawful sex discrimination by an employer to treat pregnancy of an employee any less advantageously to the female employee than other disabilities. To the same effect see *Schattman v. Texas Employment Commission,* 300 F. Supp. 328, 330, 3 FEP Cases 311, 468 (W.D. Texas). The EEOC has held that the failure of an employer to provide non-occupational sickness and accident benefits for disabilities due to pregnancy which are provided for all other non-occupational disabilities constitutes discrimination because of sex in violation of Title VII. EEOC Decision No. 71-1474 (March 19, 1971), 3 FEP Cases 588, CCH-EPG Par. 6221.

Accordingly we believe that the failure of GE to provide the same benefits under Weekly Sickness and Accident Insurance for absences due to disability from pregnancy as are provided for absences due to other non-occupational disabilities constitutes unlawful discrimination because of sex. The IUE therefore proposes that GE and IUE agree to delete from the insurance plan the next to last sentence appearing on page 18 of General Electric Insurance Plan, with Comprehensive Medical Expense Benefits, as amended January 26, 1970 ERB-32D reading as follows:

"Benefits under Weekly Sickness and Accident

> Insurance will not be payable for any absence due to pregnancy or resulting childbirth or to complications in connection therewith."

IUE proposes that in place of the foregoing sentence a sentence providing for the payment of benefits under Weekly Sickness and Accident Insurance for any and all absences due to disabilities caused by pregnancy, miscarriage or childbirth be inserted and the last sentence changed so that the last paragraph on said page 18 reads as follows:

> "Any employee absent because of disability arising from pregnancy, miscarriage or childbirth shall receive benefits under Weekly Sickness and Accident Insurance in the same amount, for the same period of time and on the same terms and conditions as if the employee had been absent for sickness. In addition there are Comprehensive Medical Expense Benefits in the event of maternity, miscarriage or childbirth if you are enrolled for such coverage."

We include as attached Exhibit C the foregoing proposed revision.

The provision in Article XIII, Section 1(e), p. 30, to the extent that it imposes the requirement that the foreman or other immediate supervisor be notified prior to the absence from work discriminates because of sex in that no such requirement of notice prior to absence from work is imposed with respect to other illnesses. IUE therefore proposes that the requirement of prior notice be deleted and the words miscarriage and childbirth be inserted so that Subsection (e), p. 30, shall read as follows:

> "(e) 'Illness' shall include pregnancy, miscarriage and childbirth."

We attach as Exhibit D to this letter the revisions in the GE-IUE National Agreement which we propose.

There are other provisions in the National Agreement which we believe should be deleted or modified in order to comply with the developing body of law under Title VII. We have *not* attempted an all-inclusive listing of such provisions, but we should point out that Article XV, 7(d) may be deemed discriminatory insofar as such provision excludes grievances arising under Article IV, 3 of the National Agreement from arbitration. We should further note that the Union has, during national negotiations, attempted unsuccessfully to have the Company agree to the elimination of many of these provisions from the National Agreement.

We urge an early meeting on the subject of effectuating the above proposals. We await your suggestions as to time and place.

Sincerely yours,

/s/ John H. Shambo, Chairman
IUE GE CONFERENCE BOARD

JHS:cds
Encls.

[EXHIBIT C]

Revisions in General Electric Insurance Plan with Comprehensive Medical Expense Benefits, As Amended January 26, 1970 (ERB-32D) proposed by IUE by letter dated February 1972, to correct discrimination against female employees who are absent due to disability arising from pregnancy, miscarriage or childbirth.

In the following, the words which have been stricken now appear in the Plan and IUE proposes that they be deleted; the words which are underlined do not appear in the Plan and IUE proposes that they be inserted:

Fourth full paragraph, p. 18

~~Benefits under Weekly Sickness and Accident Insurance will not be payable for any absence due to pregnancy or resulting childbirth or to complications in connection therewith.~~ *Any employee absent because of disability arising from pregnancy, miscarriage or childbirth shall receive benefits under Weekly Sickness and Accident Insurance in the same amount, for the same period of time and on the same terms and conditions as if the employee had been absent for sickness. In addition* there are however, Comprehensive Medical Expense Benefits in the event of maternity, *miscarriage or childbirth* if you are enrolled for such coverage.

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[EXHIBIT D]

Revisions in 1970-1973 GE-IUE (AFL-CIO) National Agreement proposed by IUE by letter dated February 24, 1972 to correct discrimination against female employees who are absent due to disability arising from pregnancy, miscarriage or childbirth

In the following, the words which have been stricken now appear in the Agreement and IUE proposes that they be deleted; the words which are underlined do not appear in the Agreement and IUE proposes that they be inserted:

Article VIII, Section 1(e), p. 30

~~(e) "Illness" shall include pregnancy, whenever the Foreman or other immediate supervisor is notified prior to absence from work,~~ *miscarriage and childbirth.*

Article XV, 7(d), p. 66

(d) Involve claims that Article I, ~~or Section 3 of Article IV~~ of this National Agreement has been violated.

PLAINTIFFS' EXHIBIT NO. 66

Facts About Women's Absenteeism and Labor Turnover, U.S. Dept. of Labor, August, 1969.

Women workers have favorable records of attendance and labor turnover when compared with men employed at similar job levels and under similar circumstances. This conclusion is supported by a careful analysis of various impartially collected statistics on absenteeism and labor turnover which also indicates that the skill level of the job, the age of the worker, the worker's length of service with the employer, and the worker's record of job stability – all provide better clues to an understanding of differences in work performance than does the mere fact that the worker is a man or a woman.

These data contradict some generalizations about the comparative labor costs of men and women. However, such generalizations are based on studies which point to the sex of the worker as the major determining factor in situations where numerous other factors have much more influence.

Before examining details of studies that consider comparable characteristics of workers, however, it is pertinent to cite the overall averages of data compiled by official or independent agencies. Even these show smaller net differences in the work records of men and women than frequently are suggested.

Overall Averages of Absenteeism

A Public Health Service study[1] of worktime lost by persons 17 years of age and over because of illness or injury shows an average of 5.6 days lost by women and 5.3 days lost by men during the calendar year 1967. Significant differences were noted between men and women in the amount of time lost because of acute or chronic illness. Women lost an average of 3.7 workdays because of acute illness, whereas men averaged just 3.3 days away from work for this reason. On the other hand, men were more likely than women to be absent because of chronic conditions such as heart trouble, arthritis, rheumatism, and orthopedic impairment.

Another analysis also has indicated that women's illnesses usually keep them away from work for shorter periods than men's illnesses do. The Health Information Foundation of the University of Chicago[2] studied the total loss to the American economy from work absences that occurred because of illness or injury between July 1959 and June 1960. Since women lost more worktime because of acute conditions and men because of chronic conditions,

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NOTE 1. – This report provides the latest data available as of June 1969.

NOTE 2. – Footnotes refer to sources listed on pages 8 and 9.

the study found that the total financial loss caused by women's absences was about the same as that caused by men's.

The Bureau of Labor Statistics, in its monthly survey of the labor force, records the incidence of illness but not its duration. During an average week in 1968, 1.7 percent of women workers and 1.5 percent of men workers were absent from work because of illness.[3] In addition, an average of 1.2 percent of the women and 1 percent of the men did not report to work for other reasons, excluding vacations. This survey does not give the full story, of course, since women have, on the average, shorter periods of absences than men.

Overall Averages of Labor Turnover

Available statistics on labor turnover also indicate that the net differences in job-leaving of men and women are generally small – even when considered on an overall basis.

Labor turnover rates, which refer to the movement of employees among firms, consist of both hiring and separation rates. The average turnover rates for men and women factory workers in 1968, collected by the Bureau of Labor Statistics on a quarterly basis,[4] are:

Type of labor turnover	Rate per 100 employees	
	Women	Men
Accessions (hires)	5.3	4.4
Separations (total)	5.2	4.4
Quits	2.6	2.2
Layoffs and other involuntary separations	2.6	2.2

Comparison of these quit rates with those analyzed in an earlier study[5] shows a narrowing of the gap between

the rates of men and women. The fact that women have become relatively less inclined to quit their jobs than they were formerly is due probably to the higher proportion of older women in the work force and the increased interest of women in continuous employment.

A study of occupational mobility by the Bureau of Labor Statistics[6] indicates that men are more frequent occupation changers than women. According to that study, only 7 percent of the women but 10 percent of the men held a different occupation in January 1966 than in January 1965. Movement between occupations was greater among young workers than among mature ones. In the 18- and 19-year-old group, more than 1 out of 4 girls and almost 1 out of 3 boys had worked in more than one occupation in 1965. Among those workers 35 years or older, fewer than 4 percent of the women and 6 percent of the men had changed occupations.

The seeming inconsistency between the labor turnover rates and the occupational mobility percentages of the two studies made by the Bureau of Labor Statistics is explained by their different coverage. The study of turnover rates referred to job changes of factory workers only. The study of mobility rates, on the other hand, measured all occupational changes but not job changes within the same occupational classification. In addition, the latter figures exclude workers who left jobs in 1965, and had not obtained new ones by January 1966, either because they were unsuccessful in their jobhunting or had voluntarily left the labor force. Since there are relatively more women than men in this category, the figures for women's occupational mobility tend to be slightly understated.

Geographic labor mobility was also found to be somewhat less among women workers than men workers in a

study made by the Social Security Administration.[7] Between 1957 and 1960, an average of 6.3 percent of women workers but 7.7 percent of men workers changed the region of their main job. The extent of regional movement among white women workers (6.4 percent) and Negro women workers (5.3 percent) was exceeded by both white men workers (7.8 percent) and Negro men workers (7.3 percent).

Another indication of women's increasing stability in the work force is revealed in trend figures on the worklife expectancy of women, as compiled by the Department of Labor.[8] These figures show that the average number of years a woman works had more than tripled from 1900 to 1960 and had increased by almost one-third in the decade 1950-60. Worklife expectancy for those women born in 1900 averaged 6.3 years; in 1940, 12.1 years; in 1950, 15.2 years; and in 1960, 20.1 years. In each case, the percentage increase in women's average worklife expectancy far exceeded that of their average life expectancy.

The expected worklife of a woman is closely related to her marital status and the number of children she has.[9] In the large group of women who enter the labor force by age 20, the relatively small number who never marry have a worklife expectancy of 45 years. This is about 10 years longer than for those women in the group who marry but have no children and about 2 to 3 years longer than for those who become widowed or divorced. For the large number of married women with children, worklife expectancy declines with the higher number of children and the later timing of the last child. A woman marrying at age 20 has a worklife expectancy ranging from 25 years if she has just one child to 17 years if she has four or more children.

* * *

Federal employees' absenteeism. A Public Health Service analysis[16] of the number of absences reported because of illness by a sample of employees in one large Federal agency corroborated the theory that employees in high-level jobs generally had fewer absences than those at lower levels, regardless of the sex of the worker. Thus, the generalization made in the report that women employees had more absences than men employees was based on the overall data, which did not take account of the fact that relatively more women than men were employed in the low grades. In addition, it was found that women employees with children generally had a greater number of absences than those without children. As a result, differences in the incidence of illness absenteeism varied much more among the women employees than among the men employees.

Since this report did not include statistical data concerning the length of each absence period – generally found to be longer for men than women –it presented only a partial story of the illness absenteeism of Federal employees in one agency.

A U.S. Civil Service Commission study[17] of sick leave records in 1961 showed relatively small difference in the total amount of sick leave averaged by women and men Federal workers – 9.6 days for women and 7.9 days for men. But even this difference narrowed in most instances when comparisons were made of women and men with similar salaries, ages, or years of service.[18] For example, in 1961 among those earning $9,000 to $10,000 a year, 6.9 days of sick leave was the average for women and 6.3 days for men.

The highest average numbers of sick days occurred

among those in the lowest salary levels – the levels where women workers are concentrated. Two groups of women had less sick leave, on the average, than their male counterparts: those 60 years of age and over (10.5 days for women, 11 days for men) and those with more than 30 years of Federal service (10.7 days for women and 11.3 days for men).

French workers' absenteeism. The importance of considering job levels and other factors in any study of absenteeism is further emphasized in an international report[20] on women industrial workers in Paris, France. The following quotation is from that report:

> Detailed study of absentee figures for large numbers of employees of both sexes and at all levels of skill discloses that the comparatively high proportion of women at the lower levels of the occupational scale (even in countries where the employment of women is a long-standing tradition) goes a long way towards explaining their frequent irregularity at work. Highly trained women occupying responsible and skilled positions are seldom absent, even if they have several children to bring up.

Conclusion. Meaningful comparisons of absenteeism and labor turnover of women and men workers must take into consideration similar job levels as well as other factors such as age and length of service. Many of the critical generalities voiced not only exaggerate overall differences but also compare dissimilar groups of men and women.

* * *

Footnotes

[1] U.S. Department of Health, Education, and Welfare, Public Health Service. Vital and Health Statistics, Current Estimates From

the Health Interview Survey, United States, 1967. PHS Publication No. 1000-Series 10-No. 52, tables 8 and 16. May 1969.

[2] The University of Chicago, Graduate School of Business, Health Information Foundation. The Economic Costs of Absenteeism. *In* Progress in Health Services, March-April 1963.

[3] U.S. Department of Labor, Bureau of Labor Statistics. Employment and Earnings, January 1969. Annual averages table A-19.

[20] Isambert-Jamati, Viviane. Absenteeism Among Women Workers in Industry. *In* International Labor Review, March 1962.

PLAINTIFFS' EXHIBIT NO. 67

Michael S. Backenheimer, Ph.D., Demographic and Job Characteristics As Variables In Absences for Illness.

Demographic and Job Characteristics As Variables in Absences for Illness

MICHAEL S. BACKENHEIMER, Ph.D.

ATTEMPTING to understand and deal with absence because of illness has caused researchers to stress its cost to industry and to business. Two facets of cost, cost to the worker and cost to the organization employing him, have been strongly emphasized (*1, 2*). The medical approach to absence stresses the need to keep the worker healthy both on and off the job. This approach has included work safety programs, annual physical examinations, immunizations, and health insrance plans. In spite of this so-called

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Dr. Backenheimer, a member of the Commissioned Corps of the Public Health Service, is a statistician with the Service's National Center for Health Statistics. Theppaper is based on a portion of his doctoral dissertation, "Some Sociological Correlates of Sick Absence Behavior," American University, 1966.

global approach, little research is available on the social and cultural aspects of behavior surrounding absences because of illness. The term "absence" as used subsequently in this paper means absence from work which the employee attributes to illness.

I believe that absence behavior is, in considerable measure, a cultural and social phenomenon. This assumption does not deny that almost all people, from time to time, suffer from illnesses that are almost totally physiological, requiring them to restrict their usual activities; however, absence behavior is often influenced by many factors other than physical illness. Parsons (*3*) has defined illness as "a state of disturbance in the 'normal' functioning of the total human individual, including both the state of the organism as a biological system and of his personal and social adjustments."

Within Parsons' context, an employee may be said to be ill when he says that he is ill. The same degree of illness in two workers may keep one off the job and not impede the other in the least. Furthermore, a person's environment, both at home and in the office, may influence his decision as to whether or not he is ill. Should he decide that he is ill, he then embarks upon the "sick role."

The status of being ill (as opposed to the status of being well) is indeed vague. Illness is subjective in that it exists when a person says that he is ill, yet society clearly ascribes to persons with this status the obligation of attempting to get well and the privilege of not going to work, which can more or less be objectively observed. Thus absence behavior has many ramifications, and I shall attempt to deal with some of its sociological dimensions in this paper.

* * *

Sex. Women had more spells of absence than men. The assumption that such difference could be attributed to age differences between sexes was not substantiated since no significant differences in age were found between men and women. No clinical or physical evidence exists to support the assumption that women are more prone to illness or disease than are men; however, it has been found that women are frequently absent because of gynecologic problems (*6*). If comparative mortality of men and women of working age can be used as a measure of illness, women prove to be healthier than men (*7*).

Women, however, may have more episodes of absence than men because of the roles society assigns to them. Within our society women can, more easily than men, be ill because the idea of a woman "not feeling right, having a terrible headache," is socially sanctioned. Thus, women are "entitled" to be absent with greater frequency than men.

Analysis of the data also revealed that women with children were more likely to have a high frequency of absences than were women without children. This observation supports the contention that women's commitment to the family constellation results in higher frequencies of absence. Mothers are, at least theoretically, more often faced with role conflict than are women without children. Thus the roles of worker and mother come into conflict, and the result is the dominance of the mother role with the worker role supported by recourse to absence behavior.

Marital status. Marital status was controlled in this study; thus no original empirical research can be offered. However, there is ample evidence in the literature that marital status does influence absences and appears to do

so differentially by sex. Married men, perhaps because of their commitment and obligations to home and family life, are absent less frequently than their single counterparts (*5*). Probably because of the same commitment, and the resulting role conflict already discussed, married female employees are absent more frequently than their never married counterparts (*8*). Thus marital status appears to be an important variable in absence behavior.

Education. Education as a variable in absence behavior served to distinguish between men with high and low frequencies of absences; that is, those men who were seldom absent because of illness were generally better educated than those who were frequently absent. However, it is probable that the number of years of schooling cannot be considered a potent variable in influencing absences. Education is intricately related to both job responsibility and occupational status, and it is probably these factors rather than education which are the more important variables in absence behavior.

Job Variables

Occupational status. Within the study, Government Service (GS) level measures occupational status; that is, the higher the GS level, the higher the status. Occupational status is felt to be an accurate measure, since salaries increase as GS level goes up. The study hypothesis was that the higher an employee's status, the lower would be his frequency of absences. In some respects absence behavior can be viewed as an opportunity system, and the opportunity to take leave is not equally distributed throughout the range of GS levels. The higher the GS level, the less the opportunity for using leave for illness. High GS level entails increased job responsibilities and obligations.

The hypothesis was borne out by analysis of the data. Persons in the upper GS levels showed less frequency of absences than did those in lower GS levels. This relationship was true for both male and female employees. This observation refutes the hypothesis that male employees have fewer absences than female employees because they have higher job statuses (GS levels). Apparently the conceptualization of absence behavior as an opportunity system is valid for the study of such behavior.

* * *

For job variables, frequency of absence because of illness decreased as job status (as measured by service grade or salary level) increased. Neither occupational grouping nor length of service in the organization was significantly related to absence behavior.

* * *

REFERENCES

(*1*) Canfield, G.W., and Soash, D.G.: Presenteeism—a constructive view. Personnel J 34; 94-97, July-August 1955.
(*2*) Plummer, N.: Absenteeism in industry. Adv Management 25: 21-24, September 1960.
(*3*) Parsons, T.: The social system. Free Press, Glencoe, Ill., 1951, p. 431.

PLAINTIFFS' EXHIBIT NO. 68A

Letter from Ruth Weyand to Ronald Wilson, National Center for Health Statistics dated April 16, 1973.

International Union of Electrical, Radio and Machine Wokers AFL-CIO and CLC

* * * * * * * *

April 16, 1973

Mr. Ronald W. Wilson, Chief
Analysis and Reports Branch
Division of Health Interview Statistics
National Center for Health Statistics
HSMHA
5600 Fishers Lane
Rockville, Maryland 20015

Dear Mr. Wilson,

As I indicated in our phone conversation last week, I am confused about the statistics concerning pregnancy and related conditions in three publications which use National Health Survey data: *Current Estimates,* United States 1971, Vital and Health Statistics Series 10, Number 79; *Disability Days,* United States 1968, Vital and Health Statistics Series 10 Number 67; and *Time Lost from Work Among the Currently Employed Population,* United States 1968, Vital and Health Statistics Series 10 Number 71. Could you please tell me:

(1) Whether the statistics used in these studies give an accurate account of the time lost from work due to pregnancy among the currently employed population? If not, why?

(2) How is pregnancy defined for purposes of the National Health Survey? Is it a sickness or a condition which restricts activity? Is the delivery period distinguished from the remainder of the pregnancy term? Are any of the complications arising from pregnancy, such as miscarriage, ectopic pregnancy, high blood pressure, or morning sickness considered a sickness?

(3) In collating data for statistics on the time lost

from work, does mandatory maternity leave at the end of the fifth or sixth month of pregnancy, required by many employers, distort statistical results?

(4) Are there any statistics which reflect the period of time which an employed woman, who is in no way restricted by her employer as to when she must stop work before the delivery and when she may return to work after the delivery, is absent from work because of her pregnancy?

Any additional information or observation you might have on the subject of disability and work absence due to pregnancy and related conditions will be most useful to me. Your prompt attention to this inquiry would be greatly appreciated. Thank you.

Sincerely,

Ruth Weyand
Associate General Counsel
International Union of Electrical Workers

PLAINTIFFS' EXHIBIT NO. 68B

Letter from Ronald Wilson to Ruth Weyand dated May 7, 1973.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION
Rockville, Maryland 20852

NATIONAL CENTER FOR HEALTH STATISTICS

May 7, 1973

Miss Ruth Weyand
1126–16th Street, N.W.
Room 6-13
Washington, D.C. 20036

Dear Miss Weyand:

This is in response to your letter of April 16 and our earlier phone conversation concerning the reporting of work-loss days related to pregnancy.

I will answer your questions in the order you asked them in your letter.

Estimates of work-loss days based on data from the Health Interview Survey as published in our reports do not accurately reflect all of the time lost from work due to pregnancy. There are two basic limitations of the data which make it inadequate to estimate total work-loss due to pregnancy. First, the Health Interview Survey does not define routine pregnancy as an illness. However, complications arising from the pregnancy are considered as illness, provided there was some restricted activity (work-loss, bed, or other restricted activity day) or medical attention connected with the complication. The actual delivery is considered as an acute condition and any associated disability days would be included.

The second major limitation of Health Interview Survey data on work-loss resulting from pregnancy is that we count work-loss only for persons who are currently employed (persons who worked or had a job during the two weeks before interview, see page 67, question 44 of 1971 "Current Estimates"). Women who drop out of the labor force during pregnancy would be excluded from our estimates of work-loss, even if we were to define routine

pregnancy as illness. Women out of the labor force could report bed days or other restricted activity days due to complications of pregnancy or delivery, but not work-loss days.

Mandatory maternity leave would not be counted as work-loss, since the leave was not the result of "complications" due to the pregnancy.

I would suggest that you contact Mrs. Catherine East, Executive Secretary of the Citizen's Advisory Council on the Study of Women, Labor Department, (110-3791). She has been working in the area of disability payments for pregnancy.

I hope this information will be helpful. If you have any further questions, please call me.

Sincerely yours,

/s/ Ronald W. Wilson
Ronald W. Wilson
Chief, Analysis & Reports Branch
Division of Health Interview Statistics

PLAINTIFFS' EXHIBIT NO. 69

Women's Bureau Pamphlet 17 (Rev.), Day Care Facts

Women's Bureau
Employment Standards Administration
U.S. DEPARTMENT OF LABOR
Pamphlet 16 (Rev.)
1973

"DAY CARE FACTS"

DAY CARE NEED

Working Mothers and Their Children

The Employment of mothers, like the employment of all women, has been rising for several decades. This expansion is expected to continue, and as a result, the need for child care services will increase.

From 1940 to March 1972 the number of women in the labor force more than doubled– from 13.8 million to 32.9 million. However, the number of working mothers increased more than eightfold– from 1.5 million to 12.7 million. In March 1972, 12.7 million mothers with children under 18 years of age were working or seeking work. Of these mothers, 4.4 million, or about 1 out of 3, had children under age 6. More than 4 out of 10 mothers who had children under 18 years were in the labor force as compared with 3 out of 10 in 1960 and less than 1 out of 10 in 1940. Projections for 1985 indicate that 6.6 million mothers aged 20 to 44 with children under age 5 will be in the labor force. This will represent a 32-percent increase between 1975 and 1985.

The number of children with mothers in the labor force increased sharply during the last decade. Nearly 26 million children under 18 years old had mothers who were working or looking for work in March 1972. More than 5.5 million of these children were under 6 years old. In 1960, 15.7 million children under 18 had working mothers, and about 4 million of these children were under age 6.

* * *

PLAINTIFFS' EXHIBIT NO. 72

Marital Status of Women in Labor Force, U.S. Dept. of Labor, March 1971-1972.

Table 1.--Marital Status of Women in the Labor Force, March 1972-71

(Women 16 years of age and over)

Marital status	Number 1972	Number 1971	Percent distribution 1972	Percent distribution 1971	As percent of women in population 1972	As percent of women in population 1971
Total	32,939,000	31,681,000	100.0	100.0	43.6	42.5
Single	7,477,000	7,187,000	22.7	22.7	54.9	52.7
Married	20,740,000	19,986,000	63.0	63.1	42.1	4.14
Husband present	19,249,000	18,530,000	58.4	58.5	41.5	40.2
Husband absent	1,500,000	1,456,000	4.6	4.6	52.2	50.4
Widowed	2,570,000	2,516,000	7.8	7.9	26.3	25.7
Divorced	2,143,000	1,992,000	6.5	6.3	70.1	70.4

Source: U.S. Department of Labor, Bureau of Labor Statistics: Summary - Special Labor Force Report, October 1972, Marital and Family Characteristics of Workers, March 1972, and Special Labor Force Report No. 144.

PLAINTIFFS' EXHIBIT NO. 73

Mothers in the Labor Force by Marital Status and Age of Children, March 1971-1972, U.S. Dept. of Labor

Table 2.--Mothers in the Labor Force, by Marital Status and Age of Children, March 1972-71

(Mothers 16 years of age and over)

Marital status and age of children	Number 1972	Number 1971	Percent distribution 1972	Percent distribution 1971	As percent of women in population 1972	As percent of women in population 1971
Mothers with children under 18 years	12,682,000	12,201,000	100.0	100.0	42.9	42.2
Married, husband present	10,452,000	10,098,000	82.4	82.7	40.5	39.7
Other women ever married 1/	2,239,000	2,103,000	17.6	17.2	59.1	59.9
Mothers with children 6 to 17 years only	8,244,000	7,874,000	65.0	64.5	52.6	52.0
Married, husband present	6,706,000	6,424,000	52.9	52.7	50.2	49.4
Other women ever married 1/	1,538,000	1,450,000	12.1	11.9	66.5	67.6
Mothers with children under 6 years 1/	4,438,000	4,327,000	35.0	35.5	31.9	31.4
Married, husband present	3,746,000	3,674,000	29.5	30.1	30.1	29.6
Other women ever married 1/	692,000	653,000	5.5	5.4	47.4	47.8
Mothers with children 3 to 5 (none under 3) 2/	1,950,000	2,025,000	15.4	16.6	38.7	38.4
Married, husband present	1,590,000	1,680,000	12.5	13.8	36.1	36.1
Other women ever married 1/	370,000	345,000	2.9	2.8	55.8	56.4
Mothers with children under 3 years 2/	2,488,000	2,302,000	19.6	18.9	28.1	27.1
Married, husband present	2,166,000	1,994,000	17.1	16.3	26.9	25.7
Other women ever married 1/	322,000	308,000	2.5	2.5	40.4	40.8

1/ Widowed, divorced, or separated.
2/ May also have older children.
Source: U.S. Department of Labor, Bureau of Labor Statistics: Summary - Special Labor Force Report, October 1972, Marital and Family Characteristics of Workers, March 1972, and Special Labor Force Report No. 144.

PLAINTIFFS' EXHIBIT NO. 74

Labor Force Status of Ever Married Women, by Presence and age of Children, March 1972, U.S. Dept. of Labor.

Table 3.--Labor Force Status of Ever Married Women, by Presence and Age of Children, March 1972

Race and presence and age of children	Population	Labor force: Number	Labor force: As percent of women in population
Women of all races			
Total	61,896,000	25,462,000	41.1
Mothers with children under 18 years	29,577,000	12,682,000	42.9
With children 6 to 17 years only	15,677,000	8,244,000	52.6
With children under 6 years 1/	13,900,000	4,438,000	31.9
With no children under 3 years 1/	5,038,000	1,950,000	38.7
With children under 3 years 1/	8,862,000	2,488,000	28.1
Women without children under 18 years	32,319,000	12,780,000	39.5
Women of Minority Races			
Total	6,590,000	3,256,000	49.4
Mothers with children under 18 years	3,439,000	1,842,000	53.6
With children 6 to 17 years only	1,754,000	1,037,000	59.1
With children under 6 years 1/	1,685,000	805,000	47.8
Women without children under 18 years	3,151,000	1,414,000	44.9

1/ May also have older children.

Source: U.S. Department of Labor, Bureau of Labor Statistics: Summary - Special Labor Force Report October 1972, Marital and Family Characteristics of Workers, March 1972.

PLAINTIFFS' EXHIBIT NO. 74
Labor Force Status of Ever Married Women, by Presence and age of Children, March 1972, U.S. Dept. of Labor.

PLAINTIFFS' EXHIBIT NO. 75

Labor Force Participation Roles and Percent Distribution of Mothers (Husand Present), by Income of Husband in 1971 and Ages of Children, March 1972, U.S. Dept. of Labor

Table 4.--Labor Force Participation Rates and Percent Distribution of Mothers (Husband Present), by Income of Husband in 1971 and Ages of Children, March 1972

Income of husband	Labor force participation rates of mothers with children: Under 6 years 1/	Labor force participation rates of mothers with children: Under 6 and 6-17 years	Percent distribution of mothers in the labor force with children: Under 18 years	Percent distribution of mothers in the labor force with children: Under 6 and 6-17 years 1/	Number in the labor force with children: Under 18 years	Number in the labor force with children: Under 6 and 6-17 years 1/	Number in the labor force with children: Under 6 years only
Number	--	--	10,452,000	6,706,000	3,746,000		
Percent	40.5	50.2	100.0	100.0	100.0		
Under $3,000	41.9	51.0	5.7	5.1	6.7		
$3,000 to $4,999	45.1	53.0	9.9	8.0	13.4		
$5,000 to $7,999	46.5	57.3	15.3	13.2	18.9		
$8,000 to $9,999	44.1	56.3	29.1	27.9	31.3		
$10,000 and over	35.5	45.1	40.0	45.7	29.6		

1/ May also have older children.

Source: U.S. Department of Labor, Bureau of Labor Statistics: Summary - Special Labor Force Report, October 1972, Marital and Family Characteristics of Workers, March 1972.

PLAINTIFFS' EXHIBIT NO. 76

Women in the Labor Force 1972 and 1971, U.S. Dept. of Labor.

1383

U.S. DEPARTMENT OF LABOR
EMPLOYMENT STANDARDS ADMINISTRATION
Women's Bureau
WASHINGTON, D.C. 20210

WOMEN IN THE LABOR FORCE
1972 AND 1971 (Annual Averages)

(Women 16 years of age and over)

Labor Force Status (numbers in thousands)	1972		1971	
	All women	Women of minority races*	All women	Women of minority races*
Total civilian population	75,868	8,730	74,043	8,345
In the labor force	33,277	4,249	32,091	4,102
16 to 19 years of age	3,587	361	3,292	334
20 years of age and over	29,710	3,888	28,799	3,768
Employed	31,072	3,767	29,875	3,658
16 to 19 years of age	2,972	222	2,725	215
20 years of age and over	28,100	3,545	27,150	3,443

WOMEN IN THE LABOR FORCE
1972 AND 1971 (Annual Averages)--Continued

(Women 16 years of age and over)

	1972		1971	
	All women	Women of minority races*	All women	Women of minority races*
Occupations of Employed Women				
Number (in thousands)	31,072	3,767	29,875	3,658
Percent	100.0	100.0	100.0	100.0
Professional and technical workers	14.5	11.2	14.5	10.6
Managers and administrators (except farm)	4.5	2.3	5.0	2.4
Sales workers	7.2	2.8	7.2	2.7
Clerical workers	34.7	23.3	33.9	22.0
Craftsmen and kindred workers	1.2	.9	1.3	1.0
Operatives, except transport	12.8	15.0	(13.3	15.4)
Transport equipment operatives**	.4	.3		
Nonfarm laborers	.9	.9	.8	1.0
Private household workers	4.5	15.2	4.9	16.5
Service workers (except private household)	17.5	26.8	17.4	27.0
Farmers and farm managers	.3	.1	.3	.1
Farm laborers and foremen	1.4	1.1	1.4	1.4
Unemployment Rates (not seasonally adjusted)				
Total 16 years and over	6.6	11.3	6.9	10.0
16 to 19 years	16.7	38.6	17.2	35.5
20 years and over	5.4	8.8	5.7	8.7
Percent of unemployed seeking part-time work	26.5	20.6	25.9	--
Full-Time/Part-Time Work (nonagriculture)				
Percent on full-time schedules	72.0	73.9	71.8	73.8
Percent on part-time schedules	28.0	26.1	28.2	26.2

*Includes all races other than white; Spanish-speaking persons are included in the white population.

**Not shown separately prior to January 1972.

Data distributed by Woman's Bureau, U.S. Department of Labor, January 1973.

PLAINTIFFS' EXHIBIT NO. 77

Report of the Commission on Population Growth
and the American Future
(Gov't Print. Off., March 1972), pp. 97-98

Chapter 11: Human Reproduction

Contemporary American couples are planning to have an average of between two and three children. Given the fact of youthful marriage, far-from-perfect means of fertility control, and varying motivation, many of these couples will have children before they want them and a significant fraction will ultimately exceed the number they want.

Recent research[1] has disclosed a substantial incidence of such unplanned pregnancies and unwanted births in the United States. According to estimates developed in the 1970 National Fertility Study conducted by the Office of Population Research at Princeton University, 44 percent of all births to currently married women during the five years between 1966 and 1970 were unplanned; 15 percent were reported by the parents as having never been wanted. (See Table 11.1.) Only one percent of first births were never wanted, but nearly two-thirds of all sixth or higher order births were so reported. In theory, this incidence of unwanted births implies that 2.65 million births occurring in that five-year period would never have occurred had the complete availability of perfect fertility control permitted couples to realize their preferences. And these estimates are all conservative.

Unwanted fertility is highest among those whose levels of education and income are lowest. For example, in 1970, women with no high-school education reported that

31 percent of their births in the preceding five years were unwanted at the time they were conceived; the figure for women college graduates was seven percent. Mainly because of differences in education and income—and a general exclusion from the socioeconomic mainstream – unwanted fertility weighs most heavily on certain minority groups in our population. We have relevant data for blacks only, but this is probably true for Mexican-Americans, Puerto Ricans, Indians, and others as well.

For example, if blacks could have the number of children they want and no more, their fertility and that of the majority white population would be very similar. These figures about our black population illustrate the inequality of access of our minority populations to the various means of fertility control, as well as to the education and income which is so closely connected with that access.

Not all unwanted births become unwanted children. Many, perhaps most, are eventually accepted and loved indistinguishably from earlier births that were deliberately planned. But many are not; and the costs to them, to their siblings and parents, and to society at large are considerable, though not easy to measure.

Table 11.1
Unwanted Fertility in the United States, 1970[a]

Race and Education	Most Likely Number of Births per Woman	Percent of Births 1966-70 Unwanted	Percent of Births 1966-70 Unplanned[b]	Theoretical Births per Woman without Unwanted Births
All Women	3.0	15	44	2.7
College 4+	2.5	7	32	2.4
College 1-3	2.8	11	39	2.6
High School 4	2.8	14	44	2.6
High School 1-3	3.4	20	48	2.9
Less	3.9	31	56	3.0
White Women	2.9	13	42	2.6
College 4+	2.5	7	32	2.4
College 1-3	2.8	10	39	2.6
High School 4	2.8	13	42	2.6
High School 1-3	3.2	18	44	2.8
Less	3.5	25	53	2.9
Black Women	3.7	27	61	2.9
College 4+	2.3	3	21	2.2
College 1-3	2.5	21	46	2.3
High School 4	3.3	19	62	2.8
High School 1-3	4.2	31	66	3.2
Less	5.2	55	68	3.1

[a] Based on data from the 1970 National Fertility Study for currently married women under 45 years of age.
[b] Unplanned births include unwanted births.

Most of the costs of unwanted fertility are not visible in the dramatic instances of abandonment or child abuse, but rather in the more prosaic problems of everyday family life. Family budgets can be seriously strained by the unexpected and unwanted birth of a child. And those who can least afford such additional burdens most often experience them. The incidence of unwanted births is

twice as great among couples whose annual incomes fall below $4,000 as it is among those with incomes of $10,000 and higher. Since most unwanted births experienced by married couples occur late in the childbearing years, the woman who had been waiting for her youngest child to be in school before returning to work can find her plans abruptly frustrated.

There are also health costs involved. As President Nixon observed:

> . . . involuntary childbearing often results in poor physical and emotional health for all members of the family. It is one of the factors which contributes to our distressingly high infant mortality, the unacceptable level of manlutrition. . .[3]

These health problems result, in part, from the fact that most unwanted births occur to women in the later years of childbearing. And these are the ages at which there are considerably greater risks to maternity. For example, although maternal mortality has declined by 94 percent over the past 30 years to a rate of 24 maternal deaths per 100,000 live births, the risks increase sharply at the older ages. Compared with the rate at age 20 to 24 when the risk is lowest, the rate is four times greater at ages 35 to 39, almost eight times greater at ages 40 to 44, and nearly 20 times greater at older ages.[4]

The risk to the infant's life is also associated with the mother's age; the infant mortality rate runs almost one-third higher among women 35 years of age and over, than among women aged 20 to 24.[5]

Because of the strong association between maternal age and the appearance of certain hereditary diseases, the prevention of births of women over 35 would reduce the

incidence of such diseases. For example, the incidence of Down's syndrome, which accounts for 95 percent of mongolism, would be reduced significantly by the avoidance of childbearing in the older ages.

How far down the road toward population stabilization would the prevention of unwanted births take us? Since fertility has been changing so rapidly in recent years, such an estimate is difficult to make. The record of women who are approaching the end of their childbearing, those 35 to 44 years old in 1970, indicates that 27 percent had at least one unwanted birth, a total of one in every six births. The prevention of the unwanted births in this group would have carried them about three-fifths of the way to the replacement level. But women in those age groups were the main participants in the post-war baby boom and have had the highest fertility of any women in modern time. And there has been a significant change downward in the family-size expectations of young couples.

* * *

PLAINTIFFS' EXHIBIT NO. 78
Prentice-Hall, Personnel Management-Policies and Practices, Report Bulletin 25, June 6, 1972, P-H Survey Maternity Leave Policies Due For A Change.

Personnel Management—
Policies and Practices
Report Bulletin 25
Volume XIX June 6, 1972
Englewood Cliffs Prentice-Hall New Jersey

P-H Survey: Maternity Leave Policies Due for a Change?

• • •

How does this affect employers? To learn the answers, the P-H Research Staff surveyed typical plants, offices and hospitals. While the majority of these firms now grant maternity leaves, more than half of them will need to review and revise their policies before they'll be in compliance with the new guidelines.

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P-H Survey: Maternity Leave Policies Due for a Change?

[¶230] Almost 3 out of 4 companies surveyed by the P-H research staff have a formal policy for providing maternity leaves. Another 20% will give a woman a leave of absence–but this decision is made on a case-by-case basis. (For instance, some firms have different policies for their plant and for their office workers.) And 5% of the respondents haven't granted any maternity leaves up to now.

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⋙ 7-YEAR PROGRESS REPORT → Shortly after Title VII took effect, in 1965, P-H surveyed over 1,000 employers on this subject. The picture was quite different: Only two-fifths of the offices granted maternity leaves; three-fourths of the plants (mostly unionized) granted leaves. But they tended to require early "retirement" from the working scene–sometimes as soon as a pregnancy was "obvious." Few employers–less than 20%–allowed the pregnant employee herself to decide how long she wanted to continue working. And in many companies, if a woman wanted to return to work after the birth of her baby, she was considered a "new hire"–with no seniority rights.

Eligibility requirements. More than one-third of respondents (but nearly 2 out of 3 hospitals) set length-of-service requirements for employees wishing maternity leaves. Commonly, they require at least 6 months' service, with one year's service the next most frequently mentioned. (Hospitals, however, most commonly require one year's service.)

Other service requirements (3 months or less) generally appear to follow companies' normal arrangements for probationary employees who may not yet be participating in other company benefit programs. On the other end of the scale, a few companies set a 9-month or 10-month service requirement (i.e., the employee could not have been pregnant when she was *hired;* this question is discussed in more detail below). No respondent required longer than 2 years' service, for a woman to qualify.

Several companies said only permanent, full-time employees were eligible for maternity leaves. And one company (where determinations have up to now been made on a case-by-case basis) said granting of leaves depended on "quality of work and personality." (If a leave was *denied*, this would appear to be a constructive discharge.)

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How long can she continue working? Generally, it's the employee - or the employee with her doctor's O.K. - who decides. Over 60% of respondents recognize that jobs and people differ, the pregnant woman decides for herself when she needs a leave for her "temporary disability."

But in 35% of responding companies, the policies spell out how long a pregnant employee can continue working. Of those firms, 6 months is the most commonly-mentioned cut-off date, with 7 to 7-1/2 months a close second. Several office firms set an 8-month deadline. A number of plants say 4-5 months. Other special cases:

- 4 months [plant doctor advised against lifting, walking up stairs]
- 6 months for production employees; no limit for office employees
- 4 months if employee has no dispensation from her doctor; 8 months if her doctor says it's O.K. [office firm]
- 7 months, if employee is exposed to radiation [hospital]

How do you know whether it's safe for her to work? Most companies—no matter what their policy on how long a pregnant employee may continue on the job—want assurance that the woman is physically able to work. Thus 3 out of 4 firms ask her to bring an O.K. from her personal doctor, with the expected date of birth noted. One company asks the employee to bring in an O.K. at 2-month intervals. About 1 in 8 companies require an O.K. from the company doctor; and 10% don't require a medical statement.

A small percentage of firms (10%) require an O.K. only if the employee is ill or works in a hazardous job. And 1 out of 6 companies have occasionally arranged transfers for pregnant employees to safer or easier jobs, if this was feasible.

What about pay for absences of employees during their pregnancy? Two out of three companies apply the same rules to pregnant employees as they apply to anyone else. However, about one-fourth of the firms will pay only for illnesses not connected with pregnancy. (One company pays for absences resulting from "complications"—but not for illnesses associated with a "normal" pregnancy.) The remaining firms don't pay for absences due to illness, whatever their cause. Do companies ask pregnant employees to stop work earlier than originally planned, if their attendance record is poor? Some 13% of respondents say Yes. Again, this decision may be made after consultation with the employee's doctor, to ensure that the job isn't endangering the employee's health.

Benefits and insurance. Two out of three respondents have temporary disability benefits plans. Of these, 54% provide coverage for pregnant employees.

What about medical and hospital insurance benefits covering maternity? Over 90% of respondents said their female employees were entitled to the same maternity benefits as the wives of male employees (provided of course that they carried a plan providing family-type coverage). Several exceptions were noted: If the female employee wasn't covered by a plan provided by her husband's employer (that is, there can be no duplication of coverage); unless she was head of household; and one firm said the protection was not offered to an individual who was unmarried. (A number of companies expected to be making changes in this area, probably in response to the new guidelines.)

☞ WHAT ABOUT ABUSES? → About 10% of respondents said they had problems with pregnant employees who claimed unemployment benefits, when their employers considered them "unavailable for work." Most of the firms that found this a problem considered it worthwhile to contest such claims. The others apparently consider the claims justified, or they pay them, as the lesser of two nuisances. (*NOTE:* Of course, those companies allowing employees to work as long as they wish, rather than setting an arbitrary quitting date, aren't generally troubled with U.C. benefit claims.)

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☞ WORKMEN'S COMPENSATION CLAIMS MAY NOT BE A PROBLEM → Although 10% of respondents have expressed concern about pregnant employees' filing claims because of a miscarriage or other injury suffered in the course of employment, this fear may not have much basis in fact. Here's why: We asked respondents whether such claims had ever come up, in their experience. And, if so, was their company held liable? Surprisingly, none of the 108 respondents said they knew of a single case!

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How long a leave do they need? How long do maternity leaves extend *after* childbirth? More than half the responding companies set some sort of limit. Either they set the earliest and the latest time after childbirth that the employee can or must return to work (or lose her right to reinstatement). Or, they spell out a limit on the *total* length of a maternity leave (including before and after childbirth). Some firms set a variety of limits, as explained below. Just over one-fifth of the companies - 22% - let the employee decide how soon she wishes to return to work after childbirth.

➢ *Earliest returns:* Of the companies setting a limit on when employees may resume work following childbirth, the most common requirement is 4 weeks or, more usually, 6 weeks after childbirth. (Note: A number of states formerly had rules prohibiting employment of women within 4-6 weeks after childbirth; a number of these laws, along with much other protective legislation tending to conflict with Title VII, have since been repealed. Check your state law on this point.)

➢ *Latest returns:* About half the companies setting limits say employees should return to work no later than 3 months after childbirth, or at least report in at that time to arrange for an extension of their leave, if desired. A few set the limit at 2 months, 6 weeks or 30 days. Others set the limit at 9 months or 1 year following childbirth.

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☞ MOST OF THE WOMEN WHO TAKE MATERNITY LEAVES COME BACK TO WORK → We asked survey respondents to tell us what proportion of their employees who were pregnant in 1971 quit their jobs and what proportion took a leave. Considering just those companies that had statistics available, half the plants, one-third of the office firms, and two-thirds of the hospitals said that 75% or more of the employees who were pregnant elected to take a leave. (In many of these cases, 100% of the employees took a leave.) And of this group, more than half reported a perfect score on "returns"—that is, all the employees who elected a leave actually returned to work as scheduled. On the other hand, some companies reported that only a fraction of employees actually returned after their babies were born (in some cases, they would have liked to return, if a suitable job opening existed).

Whether your company's experience is worse or better—depending on your point of view—you will surely have to reckon with maternity leaves from now on. And you'll have to consider ways to minimize the impact on your staff operations.

PLAINTIFFS' EXHIBIT NO. 79
Carol Greenwald, Maternity Leave Policy,
New England Economic Review, January-February 1973.

FEDERAL RESERVE BANK OF BOSTO

NEW ENGLAND ECONOMIC REVIEW

MATERNITY LEAVE POLICY

by Carol Greenwald

Maternity Leave Practices

According to a survey of 219 companies conducted by the Administrative Management Society, most firms' personnel policies in 1971 toward pregnant employees differed radically from the new Federal guidelines which took effect early in 1972.[5] The new Federal guideline states that it is up to the woman employee to determine, in consultation with her doctor, when to terminate her employment. Most firms replying to the survey had a set termination date for a pregnant employee. While answers varied widely, the largest group of firms (67) said that women employees were required to leave before reaching their sixth month of pregnancy.

The new guidelines require employers to let women employees use sick leave pay during a maternity absence as well as requiring that a woman on maternity leave receive the same payments as any other temporarily disabled employee. While 172 firms said that absences due to illness while pregnant were paid for under the company's sick leave plan, 174 companies in the survey indicated that they granted maternity leave of absence *without any pay.*

In fact, 33 firms indicated that they did not even grant maternity leaves without pay, a policy in violation of a 1968 EEOC guideline which stated that a leave of absence should be granted for pregnancy whether or not it is granted for illness. The new EEOC guideline strengthens the 1968 ruling by stating that firing employees because of absences exceeding allowed leave time may be unlawful if this practice has disproportionate impact on one sex.[6] Basically,

this means that an employer permitting employees five days leave time a year may be in violation of the law if he fires a woman who, because of pregnancy, missed several weeks of work. Employers with unreasonably short leaves have thus been put on notice that their policies may be illegal.

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Table 1

THE STRUCTURE OF THE WORK FORCE

Federal Reserve Bank of Boston

	No. of Employees	*No. of Female Employees*	*Women as % of Total*	*Women Under Age 34 as % of All Women*	*No. of Women Resigning due to Pregnancy or taking Maternity Leaves*
Dec. 1971	1568	955	61	50	22
Aug. 1972	1550	918	59	49	8

* * *

The Cost of Paid Maternity Leaves
A Case Study

To answer this question the staff of the Federal Reserve Bank of Boston was used as a case study to determine the costs the Bank would have incurred if it had implemented the new EEOC guidelines during a 20 month period from January 1971 to August 1972. Since the Bank has both a large, fairly young female staff and a generous sick leave policy, an analysis of the Bank's costs should provide a fair example of the costs employers generally could expect from the liberalization of benefits.

As Table 1 shows, the Federal Reserve Bank of Boston had approximately 1560 employees in 1971 and 1972, 60 percent of whom were women.[7] Half of the female employees were under 34 years old and were thus in the prime childbearing years. About 30 percent of the women workers were under 25 and single when hired.

Turnover was quite high among the female staff under age 34 (32 percent in 1971 and 25 percent in 1972), with pregnancy being a significant factor. Pregnancy accounted for 12 percent of the turnover in this age group in 1971 and 4.5 percent of the turnover in 1972.

At the Bank employees accumulate 18 days of sick pay a year at full pay for each year of employment, and 18 days a year at half pay, to be used after their full-day sick benefits run out. Employees may accumulate up to 270 days of sick leave at full pay. Most firms offer a less generous sick leave policy by severely limiting the accumulation of sick leave and covering longer illnesses under temporary disability insurance plans which generally pay only half to two-thirds of the employee's wages. Most disability plans generally exclude pregnancy-related ills from coverage, but under the new EEOC guidelines these restrictions must be removed. As a result of the Bank's sick leave policy, in this case study it is assumed that pregnancy leaves would be paid under accumulated sick leaves rather than under temporary disability insurance. Since this contains a large proportion of days at full pay, the analysis overstates somewhat the costs of firms which would cover maternity leaves under disability plans.

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[7] Officers of the Bank, part-time employees and very short term employees who are not eligible for medical benefits have been excluded from all data.

Since it is impossible to determine beforehand how many days a pregnant employee will be unable to work due to pregnancy-related disabilities, we used two different assumptions in the analysis. In Case A, we assumed that pregnant women would work until the end of the eighth month of pregnancy and then take one month of sick leave at full pay (if they had accumulated that many sick days). After the baby's birth, the women would take a six-week maternity leave while continuing to receive accumulated sick pay benefits. In Case B, we assumed that pregnant employees would take all their accumulated sick days either during their pregnancy or during their maternity leave. On average, employees taking maternity leaves had accumulated 5½ weeks of sick pay at full pay and 8½ weeks at half pay in 1971 and 10½ weeks at half pay in 1972. On average then, women in Case B took a maternity leave of 14 to 16 weeks at 70 percent of full pay over the entire period. In both Cases A and B it should be remembered that a doctor must certify that a woman cannot work for medical reasons for the employee to be entitled to any medical benefits. An insignificant number of women could be expected to take longer maternity leaves for medical reasons than is assumed in Case B.

Table 2

COSTS OF PAYING ACCUMULATED SICK LEAVE PAY DURING MATERNITY LEAVES

Federal Reserve Bank of Boston

	Case A *Assumes woman works through 8th mo. and then takes 6 wk. maternity leave. (Maximum 10 wk. leave.)*	*Case B* *Assumes woman collects all accumulated sick pay. (14-16 week average leave.)*[1]	*Women Under Age 35* *Average Hourly Wages, Women Under Age 35*[2]	*Increase in Hourly Wage Due to Maternity Benefits* A	B	*Percentage Increase in Hourly Wages* A	B	*Increase in Total Bank Sick Pay Benefits* A	B
1971	$16,945	$32,731	$3.29	$0.02	$0.04	0.6%	1.2%	4.6%	8.9%
Jan-Aug 1972	$6,907[3]	$11,382	$3.25	0.01	0.02	0.3	0.6	2.9	4.8
1972 (annual rate)	($10,361)	($17,073)		(0.01)	(0.02)	(0.3)	(0.6)		

[1] Maximum of 9 months of full and half days.

[2] The wage data used were basic wages, excluding overtime, in August 1972. These wages were also used for computing costs as of December 1971, except for 1971 terminations where we used 1971 wages. The use of 1972 data should not appreciably bias 1971 costs since the only Bank-wide review of salaries during this 20 month period occurred in November 1971 and we are using end of period data rather than annual averages. Some persons will have received merit increases between November 1971 and August 1972 and by using 1972 data we are biasing 1971 costs upward somewhat.

Table 3

IMPACT OF LIBERALIZED MATERNITY BENEFITS ON HOURLY LABOR COSTS: ACCUMULATED SICK PAY

Federal Reserve Bank of Boston

	Average Hourly Wage, Total Bank Labor Force	*Increase in Hourly Wage Due to New Maternity Benefits* *Case A*	*Case B*	*Percentage Increase in Hourly Wages* *Case A*	*Case B*
1971	$4.15	$.006	$. 01	0.1%	0.2%
Jan-Aug 1972	4.15	.004	.006	0.1	0.1

Paying Accumulated Sick Pay

Table 2 indicates the costs of the liberalized benefits. In 1971, under the reasonable but modest assumptions of Case A, payroll costs would have been raised by $16,945 in 1971 and by $6,907 in the first eight months of 1972. Under the more liberal assumption of Case B, $32,700 would have been added to payroll costs and in the first eight months of 1972, $11,400 would have been added (or $17,100 at an annual rate). The difference in the annual costs is due in part to chance (there were 22 pregnancies in 1971 compared to 8 in 1972) and in part to the fact that in 1971 one quite high wage employee, who had a large number of accumulated sick days, took a maternity leave. These liberalized benefits would have increased the cost of sick pay benefits in 1971 by 4.6 percent in Case A and by 8.9 percent in Case B.

To put these additional benefit costs into perspective, they are compared with the total wage bill for women under age 35 to indicate how much these additional benefits increase the hourly wage of women in this age group.

As Table 2 clearly shows, on an hourly basis, even in Case B, these increased costs averaged out to a 4 cent rise in hourly wages in 1971 and a 2 cent rise in 1972, or an increase of 1.2 percent in hourly wage costs in 1971 and 0.6 percent in 1972. In Case A, the increase in hourly costs was about half as much.

We have used women under age 35 as our base rather than all women employees or all employees, in order to confront the question of whether the cost of these maternity benefits is so great that employers would discriminate against hiring young women. Our analysis indicates that this should not be the case. This is especially true since the institution of these benefits is a one-time adjustment in levels of compensation, rather than continuing increases. That is, wage levels would rise in the year these benefits were introduced to a base, at the very most, 1.2 percent higher.

Since higher labor costs generally lead to higher prices, it is of interest to determine how much these liberalized benefits raise total labor costs. In this case, the relevant wage base for calculations is the total labor force, male and female. As Table 3 shows, labor costs per worker hour would have risen in 1971 only one cent an hour under assumption B, and by ½ cent an hour under assumption A. The 1972 costs averaged about half as much. Thus, the instititon of these liberalized benefits would have very little inflationary impact.

Table 4 indicates the actual costs incurred by the Bank for sick pay and disability benefits by age and sex of workers. For male workers over 35, these medical benefits averaged 17 cents an hour per worker in 1971 and 20 cents in 1972, while for women workers over age 35, they cost 19 cents an hour in 1971 and 17 cents an hour in 1972.

Table 4

SICK PAY AND DISABILITY BENEFITS AS A PROPORTION OF COSTS, BY AGE AND SEX OF WORKER

Federal Reserve Bank of Boston

	Men			*Women*				
				1971				
Age	*Average Hourly Pay*	*Medical Benefits, Hourly Basis*	*As % of Average Hourly Pay*	*Average Hourly Pay*	*Medical Benefits, Hourly Basis*	*As % of Average Hourly Pay*	*Cost with Liberalized Benefits, Per Hour* A	B
Under 25	$3.86	$0.08	2.1%	$3.09	$0.09	2.9%	$0.12	$0.13
25 – 34	5.40	0.10	1.9	3.71	0.11	3.0		
35 – 54	5.45	0.13	2.4	3.92	0.18	4.6		
55 & over	5.11	0.24	4.7	3.89	0.19	4.9		
				Jan-Aug. 1972				
Under 25	3.67	0.07	1.9	2.93	0.09	3.1	$0.11	$0.12
25 – 34	5.16	0.09	1.7	3.83	0.13	3.4		
35 – 54	5.55	0.16	2.9	3.87	0.16	4.1		
55 & over	5.09	0.28	5.5	3.96	0.20	5.1		

For men under 35, the costs were 9 cents an hour in 1971, and 8 cents an hour in 1972. For women under 35, these actual medical costs were 10 cents an hour in both years. After liberalizing benefits to include paid maternity leaves, as Table 4 shows, hourly costs for women under age 35 could have risen in 1971 to 12 cents an hour under assumption A and to 13 cents an hour under assumption B. Even in Case B, the cost of these medical payments to women under age 35 would still be less than that to women over 35 and to men over age 55.

Conclusion

This examination of the costs of implementing the new EEOC guidelines clearly indicates that the costs would have a negligible impact on overall labor costs and would not raise the effective wages of young women workers enough to injure them in the job market.

PLAINTIFFS' EXHIBIT NO. 80
Citizens Advisory Council on the Status of Women, Job Related Maternity Benefits, November, 1970.

JOB-RELATED MATERNITY BENEFITS

November 1970

CITIZENS' ADVISORY COUNCIL ON THE STATUS OF WOMEN
U.S. Department of Labor, Room 4211
Washington, D. C. 20210

CITIZENS' ADVISORY COUNCIL ON THE STATUS OF WOMEN

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Warren Petroleum Corp.

Mrs. Catherine East
Executive Secretary

CITIZENS' ADVISORY COUNCIL ON THE STATUS OF WOMEN
Washington, D. C. 20210

CHAIRMAN
Mrs. Jacqueline G. Gutwillig
Arizona

JOB-RELATED MATERNITY BENEFITS

The Council adopted the following Statement of Principles on October 29, 1970:

> Childbirth and complications of pregnancy are, for all job-related purposes, temporary disabilities and should be treated as such under any health insurance, temporary disability insurance, or sick leave plan of an employer, union, or fraternal society. Any policies or practices of an employer or union, written or unwritten, applied to instances of temporary disability other than pregnancy should be applied to incapacity due to pregnancy or childbirth, including policies or practices relating to leave of absence, restoration or recall to duty, and seniority.
>
> No additional or different benefits or restrictions should be applied to disability because of pregnancy or childbirth, and no pregnant woman employee should be in a better position in relation to job-related practices or benefits than an employee similarly situated suffering from other disability.

General Background

1. There is now no uniformity of treatment for disability because of pregnancy under existing job-related insurance and leave with pay systems providing protection against medical costs and/or loss of income due to

temporary disability. In the United States absences from employment necessitated by childbirth or complications of pregnancy are sometimes covered by job-related temporary disability insurance and/or sick leave plans. Sometimes such absences are excluded from such plans or included with special limits. Job-related health insurance plans may cover hospital and/or other medical costs associated with pregnancy; may cover such costs with special limitations; or may not cover maternity medical costs at all. Sometimes employees have reemployment rights after absence of a given number of weeks due to pregnancy; sometimes pregnancy is reason for discharge.

Considerable interest has been evidenced in this subject by public and private employers and unions in recent months. The Council hopes, in answer to requests, that it may be of service by suggesting what seems to us to be the most equitable and reasonable approach under our present system of private and government social benefits.

2. There are no Government data available on the extent to which medical costs of childbirth are covered in private health insurance programs; nor are there any data available on the extent to which loss of income due to absence because of childbirth is covered by private sick leave or temporary disability insurance programs.

Federal Social Security System

3. The Federal social security system of the United States does not have a national health program or insurance against loss of income for employed persons who are unable to work because of temporary disability. European countries provide maternity benefits within such

a framework. In no European country does an employer pay a higher contribution for female employees than for male employees.[1]

Federal Government Employees

4. The Federal government has for its own employees, a sick leave system providing 13 days of sick leave at full pay per year, which may be accumulated without limit. Sick leave, vacation leave, and leave without pay may be used for absences due to pregnancy. Government employees have the option, with the Government sharing in the cost, of subscribing to a variety of health insurance plans, all of which include costs of delivery and pre-natal care in their family plan coverage.

   Some State governments have sick leave systems, which may or may not cover absences because of childbirth.

Temporary Disability Insurance

5. Insurance against loss of income for employed persons unable to work temporarily because of disability is usually called "temporary disability insurance;" it may be government-sponsored or provided by employers, unions, or fraternal groups. Temporary disability insurance usually provides for less than full pay for maximum periods of about 26 weeks. Sick leave plans ordinarily provide full pay for short periods each year, with some plans permitting accumulations of unused leave from year to year.

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[1] U.S. Department of Health, Education, and Welfare, Social Security Administration: Social Security Programs throughout the World–1969, Research Report No. 31, pp. 10, 14, 22, 58, 62, 72, 74, 80, 86, 98, 110, 114, 136, 154, 164, 176, 178, 180, 196, 202, 204, 218, 226, and 242.

6. Government-sponsored temporary disability insurance systems exist in California, Hawaii, New Jersey, New York, Rhode Island, and Puerto Rico. The railroad industry also has a temporary disability insurance system administered by the Railroad Retirement Board. These systems are financed solely by employee contributions or by joint employer-employee contributions.

   Of the State laws, only those of New Jersey and Rhode Island require payment of benefits for a normal delivery, and they put limitations on these benefits which are not applicable to other disabilities.[2] Cases of abnormal delivery are usually covered.

7. Some employers and some State temporary disability systems treat childbirth as a temporary disability and some consider it a "normal physiological condition." The Council concluded that for purposes of employment it is a temporary disability. Economically it makes no difference whether an employee is unable to work at his regular job because of pregnancy or because of hernia, ulcers, or any other illness or accident; in any case he or she suffers loss of pay and has extra medical expenses.

   The notion that pregnancy is a "normal physiological condition" has been advanced as a reason for denying women benefits provided for temporary disabilities and

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[2] Those interested in further details on temporary disability insurance in the U.S. should see the Citizens' Advisory Council on the Status of Women, Report of the Task Force on Social Insurance and Taxes, p. 8 et seq. and p. 45 et seq.; also U.S. Department of Labor, "Comparison of State Unemployment Insurance Laws," BES No. U-141, Rev. August 1970.

occasionally as a reason for providing leaves of absence not provided for other disabilities. Since there are no existing systems or guides for giving leave of absence or insurance benefits for "normal physiological conditions," a variety of policies for this special category result. Some of these create an inequity between benefits because of disability due to pregnancy and benefits because of all other temporary disabilities. A woman about to give birth is temporarily disabled for work, is under the care of a physician, and is usually hospitalized.

Special Benefits

8. The Council considered whether special benefits for maternity not provided for other temporary disabilities are ever justified. Since women are subject to all the other disabilities of mankind, it can be argued that additional benefits are needed for pregnancy. This line of reasoning treats women as a class and ignores individual differences. The essence of the fair employment concept is individual rather than class treatment.

   Individual women who are not pregnant and individual men may be absent more in a given period of time because of temporary disabilities than women who are having babies during that period. The 1961 survey of the Civil Service Commission of sick leave usage by Federal employees shows small differences in the percentages of men and women having zero sick leave balances and negative sick leave balances (those who have been advanced sick leave), indicating that the present system is inadequate for a small percentage of both men and women.

   Annual Public Health Service Surveys show that women and men lose about the same amount of time

from work because of acute disabilities, including childbirth and complications of pregnancy. In 1968, men averaged 5.2 days per year and women 5.9 days per year; in 1967 it was 5.3 and 5.6 days per year.

Giving special treatment for pregnancy will inevitably lead to situations in which men and other women who are suffering from disabilities other than pregnancy will have less benefits than pregnant women. This is not sociologically or economically justified and would be divisive. In addition, in the United States where the employer frequently pays all or part of the cost of such benefits, such policies could very well result in reluctance to hire women of childbearing age.

PLAINTIFFS' EXHIBIT NO. 81

Citizens Advisory Council on the Status of Women, Information from Insurance Industry Relating to Coverage of Childbirth in Health Insurance and Temporary Disability Insurance.

CITIZENS' ADVISORY COUNCIL
ON THE STATUS OF WOMEN
Room 4211, Department of Labor Building
Washington, D.C. 20210
202-961-3791

Information from Insurance Industry Relating to Coverage of Childbirth in Health Insurance and Temporary Disability Insurance
(Employment-Related Group Policies)

Information from a representative of the Aetna Insurance and Casualty Company, which writes a goodly percentage

of health insurance and temporary disability insurance policies, shows that the difference in cost between health insurance coverage that includes care for pregnancy and childbirth and that which does not is small. Likewise, the cost of including a maternity benefit in temporary disability insurance is small. Most employment-related group health insurance policies include pregnancy as do an estimated one-half of the temporary disability insurance policies.

Aetna has given the Council *estimated* premiums for a work group that is made up of 31 to 40 percent of female employees. The estimated rates are the rates before discount for size; larger employers would pay less. For a typical good hospital, surgical and major medical package, the cost for coverage for a family would be $42.11 per month if pregnancy were not included. If maternity benefits are included for female employees only (not for wives of male employees) the cost would be 92¢ per month more per employee. If the wives of employees are included this would add $4.07 per employee to the cost.

Aetna pointed out that these figures are averages. Variations in medical costs among regions of the country and among types of industry would influence actual premiums, as well as discounts for size. The proportionate increases for pregnancy coverage, however, would be about the same whatever the basic cost.

The Aetna experts estimated that for a typical employer of 500 employees, with 31 to 40 percent female employees of an average age and marital status mix, a good hospital, surgical, major medical package without maternity coverage would have a total cost of $194,400 per year. With full coverage for both female employees and wives of male

employees, the cost would be about $212,900, or a 9 percent difference, most of the difference being for coverage of the wives of male employees.

A surprisingly high percentage of health insurance policies cover the spouses of male employees for maternity benefits but exclude the female employees. A Health Insurance Association study of employment-related group policies issued in 1969 showed that 61 percent covered maternity benefits for wives *and* female employees, *9 percent* had coverage of wives of male employees only, and 1 percent had coverage for the female employees only. The remaining 29 percent of policies written did not cover maternity.

The Council has also been given estimates on cost of including maternity leave in a typical temporary disability insurance policy for an employer who has 31 to 40 percent female employees. The Aetna experts state that a $60.00 a week benefit beginning the 8th day after an accident or the onset of illness and payable for a maximum of 26 weeks, would cost $5.70 per month per employee without a benefit for maternity leave. Aetna has had experience only with coverage of maternity benefits for a maximum of 6 weeks. Such a benefit would add 60¢ per month per employee to the cost – approximately a 10 percent increase. It was not clear as to why Aetna policies include only a 6-week benefit.

A 1969 study by the Society of Actuaries of temporary disability insurance policies issued by 11 large insurance companies showed that 9,700 policies issued had some maternity benefit, whereas 10,700 did not. In other words, a little less than one-half of these group policies issued included coverage for maternity. This study did

not include policies issued under State temporary disability insurance laws.

In summary, the economic data available concerning cost and the extent of present coverage indicates that it is entirely feasible for employers to provide the same economic benefits for absence due to childbirth as for absence due to other temporary disabilities.

June 9, 1971

PLAINTIFFS' EXHIBIT NO. 82
Jacqueline Gutwillig, Chairman, Citizens Advisory Council on the Status of Women, Address before Conference of Interstate Association of Commissions on the Status of Women, St. Louis, Missouri, June 19, 1971.

Address by
Jacqueline G. Gutwillig, Chairman
Citizens' Advisory Council on the Status of Women
June 19, 1971
Conference of Interstate Association of Commissions
on the Status of Women
St. Louis, Missouri

* * *

A word about the Council for those of you who are not familiar with us. In 1963 President Kennedy's Commission on the Status of Women in its report, *American Women*, recommended the establishment of a Council along with an Interdepartmental Committee on the Status of Women. These two groups were established immediately by Executive Order. The Interdepartmental Committee is composed of Cabinet officers and Directors of special

agencies. The Council members are private citizens appointed directly by the President and serve for an indeterminate period.

* * *

In May 1970 the Interdepartmental Committee on the Status of Women asked the Council to evaluate a report prepared by a subcommittee of the Interdepartmental Committee appointed by the previous Administration. The report included a proposal for additional leave at part pay for maternity purposes for Federal employees. (Federal employees can use sick leave and annual leave for purposes of childbirth and can take leave without pay as necessary to supplement earned leave.)

A project group of three Council members was assigned to prepare a working paper which the entire Council discussed during its subsequent meeting. It was clear from that discussion that the Council felt it was very important not to provide benefits that would discourage Federal agencies from hiring women of childbearing age. We did not want to damage women's opportunities for employment under the guise of protecting them. Furthermore, the members felt that the essence of equal opportunity was to treat women and men as individuals, not as classes.

Among the background materials considered by the Council members at that meeting were an excerpt from a statement presented by Dorothy Haener of the United Automobile Workers Women's Department to the White House Conference on Food, Nutrition, and Health; the recommendations of the 1963 President's Commission on the Status of Women; and the 1968 Council Task Force Report on Social Insurance and Taxes. Our examination of their recommendations indicated that these groups had the same concerns as we do today. We also reviewed

provisions for maternity leave in Western European countries.

Following the request for the Interdepartmental Committee to look at the Federal Government system for its own employees, there were several developments that led us to broaden the scope of our consideration to cover maternity leave generally. A number of requests for technical advice on the subject came to the Council from private employers and unions, including unions representing airline stewardesses, who only recently had won the right to continue employment after marriage. In addition, the Equal Employment Opportunity Commission was reviewing its case decisions on maternity preparatory to issuing formal guidelines. The Council, therefore, decided to try to develop a general policy recommendation suitable for private and public employers.

We found in our review and discussion that some semantic confusion exists because maternity leave has been a broad term to encompass not only leave for childbirth but in some contexts for the total period of pregnancy, and subsequent leave for child care. This confusion no doubt arose because in earlier years many women were required to stop work as soon as they knew they were pregnant. There are still some public school systems with this kind of requirement. *Most* school systems require that a teacher begin "maternity leave" at the end of the 4th or 5th month. Furthermore a few school systems still require that teachers cannot return to teach for a full year following the birth of a child. All these various kinds of leave have been referred to as maternity leave. I suspect that some of the reactions we get from employers when discussing this subject arise from this confusion.

The Council decided that for *job-related purposes* maternity leave should be that period of time a woman is unable to work because of childbirth or complications of pregnancy. We saw no rationality in requirements that pregnant women take leave while they are still physically able to work. Such policies no doubt are a hangover from the days, not so ancient, when pregnant women were shut up at home – when pregnancy was considered obscene. Naturally we held no brief for such views.

The subject of child rearing we felt was a separate topic that required separate treatment as both men and women have the responsibility to rear children. Therefore rearing of children is not considered in our paper on maternity benefits.

The Council's policy relates only to the period of time a woman is unable to work because of childbirth or complications of pregnancy. I believe this is one of the most important contributions of our consideration of this issue – that is, the semantic separation of leave for childbirth from leave for child rearing.

We also found in our review of background materials that absence due to childbirth is sometimes treated as a temporary disability and sometimes as a special condition warranting special arrangements.

The Council concluded that childbirth and complications of pregnancy are temporary disabilities *for employment purposes* because they have all the significant characteristics of temporary disabilities – (1) loss of income due to temporary inability to perform normal job duties, and (2) medical expenses. Additionally, childbirth has two clear characteristics which are associated with only the

more severe temporary disabilities – hospitalization and possible death.

The theory that pregnancy is a "normal physiological condition" has been advanced as a reason for treating pregnancy as a special condition warranting special arrangements. I don't know what "normal physiological condition" means; the more one analyzes the words, the more confusing they become, but I'm sure of one thing – medical care, hospitalization, and death are not normally associated with this phrase. I also know as a fact that the *results* of applying this concept has generally been to deny women benefits to which they are justly entitled.

Another reason that is advanced for denying women the benefits provided for other temporary disabilities is that pregnancy is "voluntary". We all know this is a weak rationalization. Pregnancy is very frequently not voluntary and besides temporary disability benefits *are* provided for other equally voluntary conditions – such as attempted suicide. Pregnancy is no more voluntary than injuries from an automobile accident while driving intoxicated and no more voluntary than the conditions associated with long term smoking.

Since we were naturally concerned with the economic impact on employers of our conclusion that childbirth is a temporary disability, we gathered all the data we could find indicating economic consequences.

We found from the annual health interview survey conducted by the Public Health Service, that in 1968 men lost on the average 5.2 days per year because of disabilities and women lost 5.9 days. In 1967, the figures were 5.3 and 5.6 days per year. In 1966, men lost more time

from work than women – 5.9 days for men and 5.6 days for women. These figures include time lost from work because of delivery and complications of pregnancy and the post-childbirth period.

The Public Health Service has done a special tabulation for us with a finer breakdown of disability conditions than is published in their regular material, which shows the relatively minor amount of time lost from work because of deliveries and disorders of pregnancy and the post-childbirth period. In the year July 1966 to June 1967 an average of *two-tenths* (.2) of a day per employed woman was lost from work for this reason. By contrast almost eight-tenths (.8) of a day was lost by women because of injuries and 1.0 day by men because of injuries. Women lost 1.3 days per year because of respiratory conditions and men lost 1.2 days. In other words, time lost from work for childbirth is only a fraction of the time lost because of other conditions.

We had a representative of the Aetna Insurance and Casualty Company, which writes a high proportion of health insurance and temporary disability insurance policies, present at our second discussion on maternity leave. The Aetna company prepared estimates for us in considerable detail but I shall give you only those data and highlights that will help you understand better how we arrived at our conclusion.

Information from that company shows that the difference in cost between health insurance coverage that includes care for pregnancy and childbirth and that which does not is very small. Likewise the cost of including a maternity benefit in temporary disability insurance is small. Interestingly enough most employment-related group health

insurance policies include pregnancy benefits, but pregnancy benefits are included in approximately only one-half of the temporary disability insurance policies.

A 1969 study by the Society of Actuaries of temporary disability insurance policies issued by 11 large insurance companies showed that 9,700 policies issued had some maternity benefit, whereas 10,700 did not. In other words, a little less than one-half of these group policies issued included coverage for maternity. This study did not include policies issued under State temporary disability insurance laws.

However, we were surprised to learn of the number of health insurance policies that cover the spouses of male employees for maternity benefits but exclude the female employees. A health insurance association study of employment-related group policies issued in 1969 showed that 61 percent covered maternity benefits for wives *and* female employees, *9 percent* had coverage of wives of male employees only, and 1 percent had coverage for the female employees only. The remaining 29 percent of policies written did not cover maternity.

In recent discussions about our recommendations, we have been asked whether insurance companies will write health insurance and temporary disability insurance policies covering maternity. The answer is categorically yes. The national experts we have been in touch with have never heard of an insurance company that would not. The general rule is that insurance companies will write any coverage the group wants. We did learn that all the temporary disability insurance policies written by Aetna have had a maximum coverage of six weeks for maternity, which seems unduly short and would not be in line with our recommendation unless comparable maximum periods

were set for other disabilities. We were not able to find out whether this was Aetna policy or whether no employer or union had wanted a longer coverage.

We have also been asked whether our policy would adversely affect an employer with respect to workmen's compensation laws. The experts at the Federal Labor Department tell us that there would be no effect unless pregnant women have a higher accident rate than other employees and even then only larger employers would be affected. The cost of workmen's compensation coverage for the largest employers (about one-fourth of the total employers, employing about three-fourths of covered employees) is based in part on an experience rating, or actual costs of covering that employer. There are no known data indicating any higher accident rate for pregnant women.

In summary, the economic data we gathered concerning cost and the extent of present coverage indicated that it is entirely feasible for employers to provide the same economic benefits for absence due to childbirth as for absence due to other temporary disabilities.

After these findings we adopted the Statement of Principle. A draft of a back-up paper was then prepared and sent to Council members by mail for comment. We distributed the finished paper as widely as our resources permitted, sending it to Chairmen of State commissions, persons on our mailing list who had specifically requested our publications, and a limited list of reporters who had authored positive stories in the past. A number of newspapers did stories, and one – the Louisville Courier-Journal – did a survey of practices of local employers.

Since the paper was issued, several teachers have brought court actions to try to change the practices of school boards. In both of the cases where we have secured full

information – Chesterfield County, Virginia and Cleveland, Ohio – the Council's recommendations were cited in the plaintiffs' briefs. In the Chesterfield County case, Judge Robert R. Merhige, Jr. adopted the Council's position in the following excerpt from his opinion:

> The maternity policy of the School Board denies pregnant women such as Mrs. Cohen equal protection of the laws because it treats pregnancy differently than other medical disabilities. Because pregnancy, though unique to women, is like other medical conditions, the failure to treat it as such amounts to discrimination which is without rational basis, and therefore is violative of the equal protection clause of the Fourteenth Amendment.

In an almost identical case in Cleveland, Ohio, a Federal district court judge ruled that such a provision was not a violation of the Fourteenth Amendment. This case is being appealed.

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PLAINTIFFS' EXHIBIT NO. 83A
Elizabeth Duncan Koontz, Childbirth and Child Rearing Leave: Job Related Benefits, 17 N.Y. Law Forum No. 2 (1971)

CHILDBIRTH AND CHILD REARING LEAVE: JOB-RELATED BENEFITS

ELIZABETH DUNCAN KOONTZ*

I. DEFINITION OF TERMS

Discussions of maternity leave in the United States have been characterized by semantic confusion, much emotion, and few facts. Maternity leave is sometimes used to refer to leave for a period encompassing all of pregnancy and six months to a year following childbirth. To some the term means a period of four months or so prior to childbirth and six months to a year following childbirth.[1] Others use the phrase to include only the period during which a woman is actually disabled by childbirth for paid employment outside the home – a very short period for most women.[2] To some it means a period during which

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1 *See* Address by Jacqueline G. Gutwillig, Chairman of the Citizens' Advisory Council on the Status of Women, at the Conference of Interstate Association of Commissions on the Status of Women, in St. Louis, June 19, 1971 [hereinafter cited as Gutwillig Address].

2 This is a standard often applied in state legislation providing for maternity coverage under temporary disability programs. *See* text and accompanying footnotes pp. 484-86 *infra:* U.S. Dep't of

(cont'd)

the employee is paid; others are referring to leave without pay.[3] Most persons concerned with women's rights include in their concept of maternity leave some right to reemployment without loss of seniority.[4]

The confusion arose, no doubt, because in earlier years many women were required by employers to stop work as soon as they knew they were pregnant and were not permitted to return for a year or two following childbirth, if they were permitted to return at all.[5] Thus, liberalization of limits on the pregnant woman's right to work has varied according to the views of legislators and private employers.

The Citizens' Advisory Council on the Status of Women[6] studied the subject and concluded that for job-related

(Footnote 2 cont'd)

Labor, Growth of Labor in the United States 294 (1967); U.S. Dep't of Labor, 1969 Handbook on Women Workers 276-77. A number of states prohibit employment of women in one or more occupations for several weeks preceding and following childbirth. *Id.* at 276.

3 *See generally* Citizens' Advisory Council on the Status of Women, Repott of the Task Force on Labor Standards 32 (1968).

4 *E.g.*, Citizens' Advisory Council on the Status of Women, Job Related Maternity Benefits (Statement of Principles adopted on Oct. 29, 1970), *reprinted in* Citizens' Advisory Council on the Status of Woman, Job Related Maternity Benefits 1 (Nov. 1970); National Organization For Women, What It's All About (goals) (undated).

5 Gutwillig Address, *supra* note 1, at 4.

6 The Council was established on Nov. 1, 1963, by Exec. Order No. 11,126, 3 C.F.R. 971 (1964), by President John F. Kennedy on the advice of the President's Commission on the Status of Women and is composed of twenty private citizens who are appointed by the President for indeterminate terms. U.S. Dep't of Labor, 1969 Handbook on Women Workers, *supra* note 2, at 294.

purposes, maternity leave should be defined as that period (or periods) of time a woman is unable to perform her job because of childbirth or complications of pregnancy.[7] The Council concluded that it is irrational to require pregnant women to take leaves of absence while they are still able to work. Such policies are left over from the days, extending into this century, when pregnant women were forced to remain at home–when pregnancy was viewed as "obscene".[8] This feeling is still widespread, frequently disguised as concern for the protection of women's interests.[9] Perhaps it would help to alleviate the semantic confusion if a new term were adopted to refer to leave for childbirth and complications of pregnancy–a term such as *childbirth leave.*

The subject of *child rearing* is a separate topic, requiring separate consideration and treatment. Only women can bear children, but both men and women are capable of rearing children. The conceptual framework of childbearing and child rearing fits both present and future reality better than a conceptual framework that assumes that childbearing and child rearing are both solely the responsibility of women. The young women feminists insist, quite logically, that assumption by men of a full share in the rearing of children would contribute to the welfare of the whole family.[10]

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7 Citizens' Advisory Council on the Status of Women, Women in 1970, at 4 (1971).

8 Gutwillig Address, *supra* note 1, at 5.

9 *See* U.S. Dep't of Labor, Laws on Sex Discrimination in Employment 7 (1970).

10 *See* Transmittal Memorandum on Job-Related Maternity Benefits from Jacqueline G. Gutwillig, Chairman to Citizens' Advisory Council on the Status of Woemn (undated).

II. RECOMMENDATION OF THE CITIZENS' COUNCIL ON THE STATUS OF WOMEN

In 1970, the Citizens' Advisory Council, after extensive study, adopted a forceful Statement of Principles, suggesting that childbirth and incapacity due to pregnancy be treated by employers and health insurers as any other temporary disability. The Council eschews discriminatorily favorable treatment for pregnant women, as well as discrimination against these workers.[11] The recommendation is especially important in view of the many state laws and judicial decisions relating to maternity and employment. There is presently a trend in both of these areas to permit women to continue to work closer to the time of childbirth, but legislative progress particularly has been sluggish.

* * *

State Temporary Disability Insurance Laws

Rhode Island in 1942 was the first state to adopt a compulsory temporary disability insurance program.[28] It was financed entirely by employee contributions of one percent of wages to a monopolistic state-administered fund. Rhode Island had few guides to follow, and its legislation was quickly drawn. The original definition of sickness provided as follows: "An individual shall be deemed sick in any week during which, because of his physical or mental condition, he is unable to perform any service for wages."[29] In 1946 the definition was changed

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28 Ch. 1200. § 1. [1942] R.I. Pub. 1..

29 Ch. 1200. § 2. [1942] R.I. Pub. 1..

to read: "An individual shall be deemed to be sick in any week in which because of his physical or mental condition, he is unable to perform his regular or customary work." [30]

The Unemployment Compensation Board held that pregnancy came within this definition and was, therefore, compensable under the law.[31] Unfortunately, however, the board did not treat pregnancy like other physical conditions. Eligibility for benefits in cases of pregnancy did *not* depend on actual inability to work as required in the law, but was based upon the existence of the condition of pregnancy. In effect, any time a woman was not working during the entire period of pregnancy, regardless of the reason, she could draw benefits (provided, of course, she met the basic requirements for eligibility.)[32]

In addition, the basic requirements for eligibility generally were so loosely drawn that a woman who voluntarily withdrew from the labor market in January, 1943, after earning fifty dollars a week for the first two weeks of the month, and who became pregnant in January, 1945, could receive benefits of $7.25 a week for 4.6 weeks in January-March 1945, two years after she had withdrawn from the labor market.[33] Under these conditions the payments for pregnancy were a heavy drain on the system. By the benefit year 1949-1950, the pregnancy claims

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30 Ch. 1744. § 2. [1946] R.I. Pub. 1..

31 G. Osborn, *infra* note 40, at 11.5

32 U.S. Dep't of Labor, Bureau of Employment Security, Rhode Island Disability Insurance Program 41 (July 1954).

33 *Id.*

constituted 22.62 percent of all claims and 30.4 percent of all benefits paid.[34]

Rhode Island has since drafted more stringent basis eligibility requirements, and has moved from its unduly loose interpretation of inability to work during pregnancy to placing greater restrictions on pregnancy benefits than are placed on benefits for other disabilities. A flat dollar limit of $250 is allowed for pregnancy. For the calendar year 1970, about ten percent of the eligible claims and seven percent of the amounts paid were for pregnancy.[35]

Since Rhode Island was the first state to adopt a temporary disability insurance system, its experience was scrutinized by other states. Its initial costly experience with pregnancy probably led to the exclusion of pregnancy in existing temporary disability insurance programs.[36]

New Jersey, which established its system in 1948, did provide in 1961 for coverage of pregnancy for a period beginning four weeks before the expected date of childbirth and ending four weeks after childbirth.[37] Complications of pregnancy before and after this period are not

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34 *Id.* at 65.

35 Dep't of Employment Security, 1970 Statistical & Fiscal Digest 38 (1971); Letter from Dep't of Employment Security to Citizens' Advisory Council on the Status of Women, Aug. 4, 1971.

36 U.S. Dep't of Labor, Womens' Bureau, Maternity Protection of Employed Women, Bull. No. 240, at 9 (1952). *See also* N. Sinai, Disability Compensation for the Disabled Sick 59 (1949).

37 N. J. Stat. Ann., tit. 43, ch. 21. § 25 (1962).

compensable.[38] About twelve percent of New Jersey's total benefit payments in 1970 were for pregnancy.[39]

Grant Osborn, in a study of temporary disability insurance, states the advantages and disadvantages of including benefits for pregnancy.[40] He points out that many women fail to return to the labor force after pregnancy and states that "many believe that payment of disability benefits to nonpermanent members of the labor force does not further the purpose of the program and should be prohibited."[41] In advancing the contrary view, he points out that "to deny benefits in all cases of pregnancy constitutes discrimination against a significant group in the labor force."[42] According to Osborn, employer groups and the insurance industry seem to be indifferent to the issue of pregnancy benefits; labor is divided, but the consensus is that higher weekly basic benefits would be preferable to granting benefits for pregnancy.[43]

State Unemployment Insurance Laws

Thirty-eight states have special pregnancy disqualifications in their unemployment insurance laws.[44] A comprehensive statement concerning unemployment insurance

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38 N.J. Stat. Ann., tit. 43, ch. 21. §39(c) (1962).

39 N.J. Dep't of Labor & Indus., Div. of Planning & Research, Temporary Disability Insurance Statistics for New Jersey 1949-1970 tables 25 & 30 (May 1971).

40 G. Osborn. Compulsory Temporary Disability Insurance in the United States (1958).

41 *Id.*

42 *Id.*

43 *Id.*

44 *See* Manpower Admin., U.S. Dep't of Labor, Comparison of State Unemployment Insurance Laws. Comparison Revision, ser. 2, No. 4 (Jan. 5, 1970).

and pregnancy is included in the 1968 report of the Task Force on Social Insurance and Taxes of the Citizens' Advisory Council on the Status of Women. The Task Force points out that women are usually physically able to work during part of their pregnancies and thus fail to meet basic eligibility requirements for the entire period. The report also notes that women who are required by pregnancy to leave their jobs encounter obstacles to reemployment.[45]

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45 The Task Force stated:

> the special provisions arise out of the difficulties of determining the benefit eligibility of pregnancy women. Since, under all our unemployment insurance laws, benefits are payable only to those unemployed workers who are able to work and available for work, a pregnant woman who is physically unable to work or does not want to work is not eligible for benefits under the normal 9 months of their pregnancy, even though they would all have some period of inability to work, at least at the time of childbirth. How long before confinement a woman becomes unable to work depends also on the nature and physical demands of that job.
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> If a pregnant woman loses her job, her pregnancy presents an obstacle to reemployment. There are, however, serious policy implications involved in measuring an individual's availability for work in terms of employer willingness to hire individuals in that category whether the category is pregnant women, workers over 55, the physically or mentally handicapped, or members of minority groups.
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> Although the special provisions may have administrative advantages, they are not without their own difficulties. More important, they are inequitable to many women, particularly those who have lost their jobs because of lack of work while pregnant.

Citizens' Advisory Council on the Status of Women, Report of the Task Force on Social Insurance and Taxes 24 (1968).

For example, under Minnesota law a woman "laid off" by her employer at the end of the fifth month of pregnancy would not be entitled to unemployment insurance for any part of the pregnancy, even though she were able and eager to work. Furthermore, after she returned to work, she would not be eligible for unemployment insurance in the event of a lay-off until she had been employed six weeks.[46]

In view of constitutional challenges in the courts and the likelihood of passage of the Equal Rights Amendment and other legislation extending prohibitions against discrimination because of sex, the Labor Department in December of 1970 urged and warned states to eliminate sex-discriminatory provisions, specifically mentioning the pregnancy provisions.[47] Results have been negligible.

IV. FEDERAL GUIDELINES FOR MATERNITY LEAVE

The Office of Federal Contract Compliance, which administers Executive Order 1246,[48] prohibiting discrimination by federal contractors has issued guidelines prohibiting

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46 Minn. Stat. Ann. §268.09 (1959), *as amended* (Supp. 1971).

47 U.S. Dep't of Labor, Unemployment Insurance Letter No. 1097 (Dec. 31, 1970). An up to date list of pregnancy disqualification provisions appears in Manpower Admin., Comparison of State Unemployment Insurance Laws, *supra* note 44.

48 Exec. Order No. 11.246.3 C.F.R. 339 (1965) enunciated a policy of equal employment opportunity in government employment and included federal contractors, subcontractors, and federally assisted construction contracts in regard to race, creed, color and national origin. This order was amended in 1967 by Exec. Order No. 11.375.32 Fed. Reg. 14303 (1967), to expressly include sex-discrimination.

discriminatory treatment in regard to reinstatement and seniority of women taking maternity leave. The Compliance Office dictates that employers must permit leaves of absence for reasons of pregnancy, even where the employer has formulated no general policy permitting such leaves.[49] While these guidelines do not prohibit an employer from requiring a woman to take leave when she is able to work, the Office of Federal Contract Compliance has stated on another occasion that the determination of when maternity leave is to commence ordinarily is to be made by the employee and her physician.[50]

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50 The O.F.C.C. Guideline reads in pertinent part:

> (1) Women shall not be penalized in their conditions of employment because they require time away from work on account of childbearing. When, under the employer's leave policy the female employee would qualify for leave, then childbearing must be considered by the employer to be a justification for leave of absence for female employees for a reasonable period of time. For example, if the female employee meets the equally applied minimum length of service requirements for leave time, she must be granted a reasonable leave on account of childbearing. The conditions applicable to her leave (other than the length thereof) and to her return to employment, shall be in accordance with the employer's leave policy.
>
> (2) If the employer has no leave policy, childbearing must be considered by the employer to be a justification for a leave of absence for a female employee for a reasonable period of time. Following childbirth, and upon signifying her intent to return within a reasonable time, such female employee shall be reinstated to her original job or to a position of like status and pay, without loss of service credits.

Job Policies and Practices, 41 C.F.R. §60-20.3(g)(1)-(2) (1971).

The Equal Employment Opportunity Commission (E.E.O.C.)[51] has not issued guidelines specifically dealing with maternity leave, but has established certain principles

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50 On November 12, 1970, the Office of Federal Contract Compliance issued the following question and answer to its agency compliance officers:

> Q. May a contractor specify the time when maternity leave shall begin?
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> A. Not normally. This is primarily a medical decision which is not reasonable for a contractor to make in terms of a blanket policy. The time when a woman leaves before childbearing is normally a matter between the pregnant employee and her doctor.

Memorandum to heads of Agencies from John L. Wilkes, Director, Office of Contract Compliance, Dep't of Labor, Questions and Answers Concerning Sex Discrimination Guidelines, Nov. 12, 1970.

51 The Equal Employment Opportunity Commission, created pursuant to §705 of Title VII of the Civil Rights Act of 1964, 42 U.S.C. §§2000e *et seq.* (1964), is charged with administering and enforcing Title VII. Generally, E.E.O.C. investigations are initiated by the filing of a charge by a person alleging employment discrimination. This charge must be filed within ninety days of the alleged unlawful practice, except that if the state or locality where the practice occurred has a law dealing with the subject, the charge must be filed within two hundred and ten days or within thirty days of termination of the state or local proceedings. If the alleged unlawful employment practice has occurred in a state or locality which has a law prohibiting the practice alleged, the E.E.O.C. must defer the charge to that state or local agency for sixty days (unless that agency terminates earlier) before the Commission can assume jurisdiction. After a full investigation of the issues raised in the charge, the Commission issues a Finding of Fact on the allegations. The parties involved then have an opportunity to file objections and cross-objections to the Finding of Fact. The Finding of Fact is used as the basis for the issuance

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regarding rehiring policy through its decisions.[52] Sonia Pressman Fuentes, Director of the Legislative Counsel Division of the Office of the General Counsel, E.E.O.C., has expressed the Commission's opinion that employers must make reasonable provisions for childbirth leave. She feels that the Commission's principles require that employers permit maternity leaves with a right to reinstatement for married and unmarried women.[53]

(Footnote 51 cont'd)

of a Commission decision. If the decision holds that reasonable cause exists to believe that the respondent has violated Title VII as alleged, the E.E.O.C. attempts to negotiate an informal conciliation agreement. Failing settlement through conciliation, the Commission will issue a Notice of Right to Sue which authorizes the charging party to institute a civil action in the appropriate United States district court. A Notice of Right to Sue can be requested thirty days after the charge has been filed or at any time thereafter during the proceedings. Without first filing a charge with the Commission and receiving a notice of right to sue authorization, the complaining party may not institute suit under Title VII, 42 U.S.C. §§2000e *et seq.* (1964).

52 E.E.O.C. Decision No. 71-562, CCH Employment Practices Guide, ¶6184, at 4312 (Dec. 4, 1969); E.E.O.C. Decision No. 71-413, CCH Employment Practices Guide, ¶6204, at 4346 (Nov. 5, 1970); E.E.O.C. Decision No. 71-308, CCH Employment Practices Guide, ¶6170, at 4286 (Sept. 17, 1970; E.E.O.C. Decision No. 70-600, CCH Employment Practices Guide, ¶6122, at 4217 (Mar. 5, 1970); E.E.O.C. Decision No. 70-360, CCH Employment Practices Guide, ¶6084, at 4130 (Dec. 16, 1969).

53 Mrs. Fuentes stated:

> The Commission has established the principle that, as a general rule, an employer may not terminate an employee who is compelled to cease work because of pregnancy without offering her, alternatively, a leave of absence

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The Equal Employment Opportunity Commission, appeared as amicus curiae in *Schattman v. Texas Employment Commission,*[54] arguing that an employer's policy of compelling female employees to resign after reaching a certain month of pregnancy constitutes a violation of Title VII of the Civil Rights Act of 1964. The Commission took the position that such a policy would be acceptable under Title VII only where it could be shown that all or substantially all women were unable to perform safely and efficiently the duties of their particular jobs upon reaching the time established by the employer.[55]

(Footnote 53 cont'd)

> with the right of reinstatement to the position vacated at no loss of seniority or any of the other benefits and privileges of employment. While the employee is out on maternity leave, the employer should attempt to keep her job open or filled on a temporary basis. The Commission has found that, absent a showing of business necessity, an employer's conditioning of maternity leave on two years of employment violated the Act where leaves of absence and disability leaves were not subject to any similar requirement, that an employer's policy of granting maternity leave only to married female employees violated the Act in the absence of a provision for the termination of unmarried fathers, and that, absent a showing of business necessity, an employer's refusal to credit an employee for time spent on maternity leave taken prior to the effective date of the Act constituted an unlawful present effect of past discrimination.

Fuentes, *Federal Remedial Sanctions: Focus on Title VII,* 5 Valp. U.L. Rev. 390-91 (1971).

54 330 F. Supp. 328 (W.D. Tex. 1971).

55 Brief for E.E.O.C. as amicus curiae, Schattman v. Texas Employment Comm'n, *id.*

The Equal Employment Opportunity Commission has also held in violation of Title VII an employer's insurance plan affording maternity benefits only to those employees who have head-of-household status,[56] as well as a group health insurance plan providing immediate maternity benefits for wives of male employees but conditioning the eligibility of female employees on two years of employment.[57] More recently, the Commission has found that women employees were unlawfully discriminated against by an employer's insurance program which specifically excluded pregnancy from the list of physical disabilities for which weekly benefits were paid.[58]

V. LEAVES OF ABSENCE AND INSURANCE COVERAGE

There is very little data on the extent to which women employees have any job protection following childbirth or the extent to which health insurance, temporary disability insurance, and sick leave plans exclude childbirth. The Bureau of Labor Statistics in a 1970 study of 252 collective bargaining agreements covering five thousand workers or more, found that seventy-four (about twenty-nine per cent) of the agreements had some leave-of-absence provision for maternity. These seventy-four agreements extended coverage to almost one-fourth of the total number

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56 E.E.O.C. Decision No. 70-495, CCH Employment Practices Guide, ¶6110, at 4162 (Jan. 29, 1970).

57 E.E.O.C. Decision No. 71-1100, CCH Employment Practices Guide, ¶6197, at 4333 (Dec. 31, 1970).

58 E.E.O.C. Decision No. 71-1474, CCH Employment Practices Guide, ¶6221, at 4382 (Mar. 19, 1971).

of employees covered by such plans. The data does not indicate whether the plans provided compensation during leaves of absence.[59] The same study shows that eighty-two of the agreements provided for sick leave, but does not state how many of the plans permit use of sick days for childbirth.[60]

An estimated eighty-one percent of all persons under age sixty-five are covered by insurance for hospital care and 78.8 per cent for surgical services, according to statistics compiled by the Social Security Administration.[61] A study by the Health Insurance Institute of new policies issued in the first quarter of 1970 indicated that about sixty-one per cent of the employees covered had maternity coverage – for employees and spouses of employees – usually with a special maximum.[62] Almost two-thirds of all wage and salary workers are covered by some form of protection against loss of income due to temporary disability, and 33.7 per cent of all wages lost for this reason in 1969 were replaced, according to estimates by the Social Security Administration.[63]

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59 U.S. Dep't of Labor, Bureau of Labor Statistics, Characteristics of Agreements Covering 5,000 Workers or More, Bull. No. 1686 (1970).

60 *Id.* at 48.

61 Mueller, *Private Health Insurance in 1969: A Review*, Social Security Bulletin 3-4 (Feb. 1971).

62 Health Insurance Institute, New Group Health Insurance 10 (1971).

63 Price, *Cash Benefits for Short-Term Sickness 1948-69*, Social Security Bulletin 19 (Jan. 1971).

Since many of the plans protecting against loss of income exclude childbirth, there is no reliable information on the number of women employees covered. A 1969 study by the Society of Actuaries of temporary disability insurance policies issued by eleven large insurance companies showed that 9,700 of the policies issued had some maternity benefit, whereas 10,700 did not. This study did not include policies issued under state temporary disability insurance laws.[64] In a digest of one hundred health and insurance plans under collective bargaining, compiled by the Labor Department in early 1966, all health insurance plans included some provision for maternity, but most had special limitations.[65] Some provided total allowances as low as $75, $130, and $150 for maternity.[66] The same study indicated that sixty of the plans included some protection against loss of income for childbirth, most frequently with a six week limitation. All of the plans had protection against loss of income for other disabilities.[67] This study is not representative, since it included only plans that were negotiated by collective bargaining and included health and insurance provisions. Some employers unilaterally and some collective bargaining agreements require that women resign or begin leave at some special period before anticipated childbirth – most commonly at the end of the

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64 Society of Actuaries, 1969 Reports of Mortality and Morbidity Experience No. 2, at 168 (1970).

65 U.S. Dep't of Labor, Bureau of Labor Statistics, Digest of 100 Selected Health Insurance Plans Under Collective Bargaining, Early 1966, Bull. No. 1502 (Sept. 1966).

66 *Id.* at 12, 40, and 32.

67 *Id.*

fourth or fifth month of pregnancy.[68] For example, according to a survey of the National Educational Association in 1965, most school systems require that teachers take leave beginning at the end of the fourth or fifth month;[69] some school systems require a teacher to remain on leave for a full year following the birth of a child, and some give her no reemployment rights at all.[70] In others, she is reemployed only if there is a suitable vacancy.

The extent of this practice is hard to gauge. Some rough idea of the extent of the practice in New Jersey is available from data compiled by the New Jersey Department of Labor and Industry.[71] Because of its financing arrangements, New Jersey has separate data on claims arising within fourteen days of leaving employment and claims arising during employment. In 1970, 17.8 per cent of all claims were claims arising during unemployment, whereas over 71 per cent of all pregnancy claims arose during unemployment.[72] The department explains the difference: "Since the practice of many employers had been to lay off the employee significantly earlier than four weeks prior to expected birth, the bulk of payments for pregnancy

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68 *See* Larkin, *Policies Vary on Maternity Leave,* Louisville Courier-Journal, Jan. 4, 1971, Women's News at 1, col. 1; Letter from R.I. Dep't of Employment Security to Citizens' Advisory Council on the Status of Women, *supra* note 35.

69 National Educ. Ass'n. Educational Research Service Circular No. 3 (Mar. 1966) (out of print).

70 *Id.*

71 N.J. Dep't of Labor & Indus., Div. of Planning & Research, *supra* note 39.

72 N.J. Dep't of Labor & Indus., Div. of Planning & Research, *supra* note 39, at tables 23 & 30.

were paid through the disability-during-unemployment program."[73] This practice certainly results in unnecessary expenditure of unemployment insurance funds, raises the rates of many employers, and creates pressures to establish the kinds of arbitrary disqualifications referred to above. It is another example of how irrational factors determine the treatment of women employees, even when economic factors would dictate otherwise. The New Jersey data also indicate that the average number of weeks compensated for pregnancy claimants who have recently been in the labor force is 6.9; for claimants who are unemployed, the period is 7.4 weeks.[74]

VI. LABOR UNION POLICIES

Unions have generally advocated maternity leave, but the extent to which contracts provide reemployment or other benefits is still difficult to gauge. The AFL-CIO resolutions adopted at its 1969 convention included support of "adequate maternity leave and benefit plans."[75] Similarly, the United Auto Workers, in a 1970 convention, resolved that a nationwide system be developed to insure that temporary disability plans include pregnancy

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73 N.J. Dep't of Labor & Indus., Div. of Planning & Research, Two Decades of Temporary Disability Insurance in New Jersey 15 (Mar. 1970).

74 N.J. Dep't of Labor & Indus., Div. of Planning & Research, *supra* note 39, at table 33.

75 AFL-CIO, 8th Constitutional Convention, Resolution No. 236 (Oct. 1969).

coverage.[76] United Auto Workers representatives have stated that most of their contracts provide for six weeks of temporary disability insurance coverage for pregnancy.[77]

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[76] The UAW Resolution reads in pertinent part:

> *Maternity benefits, in the form of cash payments to replace the lost wages of women workers, are a logical part of a broader program of replacement of wages lost because of short-term illness.* . . . Most states have arbitrary time limits in regard to collecting unemployment compensation before and after childbirth which do not reflect the variation in physical ability of women workers, their health, or the demands of the job. *Federal standards, should be enacted permitting women to collect unemployment compensation before and after childbirth whenever they are physically able to work and to guarantee job protection for women who desire to return to work after pregnancy.* . . .
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> . . . .
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> 5. That a general system of basic statutory protection for men and women against wage loss due to temporary disability, including illness, pregnancy and maternity, be provided in one insurance program.
>
> 6. That statutory regulations be enacted and in the meantime contract clauses be negotiated establishing job security during maternity leave, with standards that encompass reasonable tests for the ability and capacity of the individual to work, recognize the physical health of the woman and the nature of her occupation, and which would not deny either employment, or unemployment compensation, when these standards are met.

22nd Constitutional Convention, 1970 UAW Resolutions, reprinted in UAW Women's Dep't, Women in Society and the 50th Anniversary of Woman's Right to Vote 5-8 (1970) (emphasis added).

[77] Interview with Dorothy Haener, International Representative, UAW Women's Dep't, in Washington, D.C., Oct. 8, 1971.

A survey of Detroit employers conducted by the Detroit News in May, 1971 indicated that American Motors Corporation, Ford Motor Company, and Chrysler Corporation (all bargaining with the UAW) do not require employees to leave or return at a specified time and that returning employees could "bump" employees with less seniority if necessary to effect reemployment.[78] The UAW has a model maternity clause antedating 1946, which recommends that contracts provide for a maximum of one year's leave of absence during which time the employee would retain and accrue seniority.[79]

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[78] Detroit News, 16 *Companies Report Their Maternity Leave Policies*, May 23, 1971.

[79] UAW Women's Dep't, UAW Policy Established by Convention Resolutions Relative to Women Workers' Rights 21 (undated) (includes resolutions adopted at 1942-1968 conventions). The American Newspaper Guild Model Contract includes the following:

> Art. V(a) Maternity leave of at least six months shall be granted upon request, with pay for at least ? weeks. No employee shall be required to take a leave of absence, nor shall an employee's job duties or working conditions be altered without her consent, on account of pregnancy; nor shall there be any penalty for pregnancy. An employee who at the end of maternity leave decides not to return to work shall be paid the amount of severance pay which would have been due less the amount of maternity pay.

American Newspaper Guild, Equality Now! A Report to the 1970 ANG Conference on Sex Discrimination and Women's Rights in the Industry at CB8 (1970). However, seventy-nine of 114 contracts surveyed in November 1970 either specified no compensation for maternity leave or were silent on the subject. *Id.* at M2.

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The International Union of Electrical, Radio, and Machine Workers has been attempting in the last few years to extend the benefits attached to other temporary disabilities to childbirth and to cut back arbitrary periods of leave.[83] The IUE has recently advised its locals of the E.E.O.C. decision holding that exclusion of maternity from temporary disability insurance coverage constitutes a violation of Title VII and has instructed the locals to instruct female employees going on maternity leave to claim benefits even though the contract does not so provide. If benefits are not paid, the employees have been instructed to file an appropriate grievance or protest and failing satisfactory settlement, to file a charge with the E.E.O.C.[84] The current IUE contract with General Electric defines illness to "include pregnancy whenever the foreman or other immediate supervisor is notified prior to absence from work."[85] The current contract with Westinghouse provides for maternity leave without pay but does include reemployment rights and does not contain an enforced period of absence.[86]

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83 Interview with Ruth Weyand, Counsel for IUE, in Washington, D.C., Oct. 8, 1971.

84 IUE, Keeping up with the law 117-18 (May-June 1971).

85 1970-73 G.E.-IUE National Agreement, art. VIII(1)(e).

86 Agreement and Pension and Insurance Agreement between Westinghouse Electric Corp. and IUE, AFL-CIO-C.L.C., XVII, Feb. 28, 1970.

VII. RECOMMENDATIONS OF FEDERAL WOMEN'S ADVISORY GROUPS

The recommendations of federal women's advisory groups have generally assumed that pregnancy is a temporary disability and should be treated as such. They have differed on means of reaching this goal.

The Citizens' Advisory Council on the Status of Women is one of the first organizations to treat the subject in depth and has addressed its recommendation to immediate change within the present framework of fringe benefits in the United States, rather than long-range solutions through proposed federal legislation. The Council has also consciously separated the concepts of childbearing and child rearing.[87]

The Chairman, Mrs. Jacqueline G. Gutwillig, stated in a recent address that the Citizens' Advisory Council views childbirth as a temporary disability for that period during which the woman is actually unable to work. The Council

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87 Jacqueline Gutwillig clearly presents the Council position:

> The subject of child rearing we felt was a separate topic that required a separate treatment, as both men and women have the responsibility to rear children. Therefore rearing of children is not considered in our paper on maternity benefits.
>
> The Council's policy relates only to the period of time a woman is unable to work because of childbirth or complications of pregnancy. I believe this is one of the most important contributions of our consideration of this issue, that is, the semantic separation of leave for childbirth from leave for child rearing.

Gutwillig Address, *supra* note 1.

recommends inclusion of maternity coverage in all group health and temporary disability insurance plans.[88] Council Chairman Gutwillig also stated, however, that the Citizens' Advisory Council felt it was very important not to

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[88] Chairman Gutwillig stated:

> We also found in our review of background materials that absence due to childbirth is sometimes treated as a temporary disability and sometimes as a special condition warranting special arrangements.
>
> The Council concluded that childbirth and complications of pregnancy are temporary disabilities *for employment purposes* because they have all the significant characteristics of temporary disabilities – (1) loss of income due to temporary inability to perform normal job duties, and (2) medical expenses. Additionally, childbirth has two other characteristics which are associated with only the more severe temporary disabilities – hospitalization and possible death.
>
> The theory that pregnancy is a "normal physiological condition" has been advanced as a reason for treating pregnancy as a special condition warranting special arrangements. I don't know what "normal physiological condition" means; the more one analyzes the words, the more confusing they become, but I'm sure of one thing – medical care, hospitalization, and death are not normally associated with this phrase. I also know as a fact that the *result* of applying this concept has generally been to deny women benefits to which they are justly entitled.
>
> Another reason that is advanced for denying women the benefits provided for other temporary disabilities is that pregnancy is "voluntary." We all know this is a weak rationalization. Pregnancy is very frequently not voluntary, and besides temporary disability benefits *are*

(cont'd)

provide benefits that would discourage employers from hiring women of childbearing age.

> We did not want to damage women's opportunities for employment under the guise of protecting them. Furthermore, the members felt that the essence of equal opportunity was to treat women and men as individuals, not as classes.[89]

* * *

IX. CHILD REARING LEAVE

So far this article has been generally limited to absences related to childbirth – the frequent denial or restriction of customary job benefits and arbitrary separations unrelated to a woman's desires or ability to do the job. Before going on to means of correction, let us consider briefly child rearing leave, which is a very new concept.[107]

(Footnote 88 cont'd)

> provided for other equally voluntary conditions – such as attempted suicide. Pregnancy is no more voluntary than injuries from an automobile accident while driving intoxicated and no more voluntary than the conditions associated with long term smoking. . . .
>
> In recent discussions about our recommendations, we have been asked whether insurance companies will write health insurance and temporary disability insurance policies covering maternity. The answer is categorically yes. The national experts we have been in touch with have never heard of an insurance company that would not. The general rule is that insurance companies will write any coverage the group wants.

[107] Child rearing leave was discussed by the Women's Caucus of the American Sociological Association in September 1969. The Caucus's formal proposals recommended that American universities grant parenthood leave. *See* American Sociologist, Feb. 1969.

While those school boards and employers who have required new mothers to take long leaves of absence following childbirth with no right to reemployment may have considered this "child rearing" leave, it is not a proper definition of the term. Child rearing leave should be with reemployment rights, optional with the employee, and available to both mothers and fathers.

There are many reasons why a working mother or father with a firm attachment to the labor force might wish or be forced to take full-time care of an infant for a temporary period. For example, a mother might want to nurse the baby; or a parent might need to care for the infant until other arrangements could be made; some young couples are planning to alternate periods at home for child rearing; or the death of a mother might require the full time presence of the father until child care arrangements could be made.

Most employers provide for other types of unpaid leave for no more important purposes, such as continuation of education and personal emergencies. It would seem that an employer who permits unpaid leaves of absence for other purposes should be willing and able to include leave of absence for child rearing.

X. THE FUTURE

Title VII of the Civil Rights Act of 1964,[108] state human relations laws, and the fourteenth amendment are clearly weapons for attacking the exclusion of, or special limitations on, pregnancy in public and private plans for

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[108] 42 U.S.C. §§2000e *et seq.* (1964).

economic assistance to the temporarily disabled. It seems certain that the courts, after full consideration, will adopt the obvious conclusion that pregnancy is a temporary disability and that women are entitled to the same autonomy and economic benefits in dealing with it that employees have in dealing with other temporary disabilities.

* * *

The prompt removal of inequities in existing systems is a high priority goal, as many low-income women workers are suffering great hardship through unjust denial of economic benefits and arbitrary restrictions on employment. With the median earnings of white women working year-round, full-time at a little over five thousand dollars per year and black women at four thousand dollars per year,[109] it is clear that most women workers cannot afford any unnecessary loss of wages or loss of coverage of medical bills.

Groups concerned with human rights should make full use of the courts and human relations agencies to challenge employers' special requirements regarding length of absence for childbirth, exclusion of childbirth from health insurance and temporary disability insurance coverage, special disqualifications for pregnancy in unemployment insurance laws, and the exclusion of pregnancy from state temporary disability insurance laws.

* * *

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[109] U.S. Dep't of Commerce, Bureau of the Census, Income in 1969 of Families and Persons in the United States, at table 50 (Current Population Reports: Consumer Income P-60, No. 75, 1970). *See also Hearings on H.R. 16098 before the Special Subcomm. on Education of the House Comm. on Education and Labor,* 91st Cong., 2d Sess., pt. 2, at 1107-18 (1970).

PLAINTIFFS' EXHIBIT NO. 83B
Addendum for Childbirth and Child Rearing Leave: Job-Related Benefits by Elizabeth Duncan Koontz, N.Y. Law Forum, Vol. 17, No. 2, 1971.

Addendum for "Childbirth and Child Rearing Leave: Job-Related Benefits" by Elizabeth Duncan Koontz, *New York Law Forum,* Vol. 17, No. 2, 1971.

Page 486, first paragraph, add:

Because of New Jersey's unusual funding arrangements, this does not mean that pregnancy benefits amount to twelve percent of the total costs of temporary disability insurance. Forty-seven percent of covered employees are covered under private insurance or employer self-insurance, which meets State standards. The others are covered by the State plan. However, *all* payments for temporary disability arising more than 14 days after the employee is laid off come out of the State Disability-During-Unemployment Fund. Seventy-one percent of *all* pregnancy claims are paid out of this fund (primarily because of the employer's practice in laying women off significantly earlier than four weeks prior to expected birth). There are no data available on total payments from private plans for maternity so it is not possible to get an accurate figure on maternity costs for New Jersey's system. It is reasonable to assume that approximately 47 percent of all the payments from the Disability-During-Unemployment Fund and approximately 47 percent of the maternity cases are for employees covered under private plans. With this assumption 8.5 percent of the costs of State plans are for maternity.

* * *

FRINGE BENEFITS:

Wages or Social Obligation?

An Analysis with Historical Perspectives from Paid Vacations

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REVISED EDITION

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Introduction

THIS is the second edition of a book on the conceptual nature of fringe benefits. Except in two significant respects, little has changed since the book first appeared in 1964.

Unchanged is the character of the fringe benefit movement—essentially management. Despite the unions' long postwar effort to challenge management's hegemony, the fringe benefit movement developed along the lines management wanted.

Unchanged, too, is the controversy over whether fringe benefits are wage payments for an employee's actual work or a non-wage obligation to cover certain off-the-job social costs of the employee. This controversy is the negotiating parties' public battleground for control of the fringe benefit money. The employer wants qualifying provisions that will protect his financial return in providing the benefit; the employee seeks as clear a title to the fringe benefit money as he would have had if the money had gone into a wage increase, which he (mistakenly) believes it could have done.

* * *

The two significant changes since 1964 are: first, the unions have lost and given up their attempt to control the fringe benefit money; second, a new political reaction to the very success of the fringe benefit movement as a substitute for social legislation may be building up. There are signs of possible trouble ahead from the very poor, on the one hand, and from the very rich—a handful of banks—on the other (Chapter 10).

In giving up the fight for control of the fringe benefit money, the employees are returning to their historical attitude toward employee benefit programs designed to increase productivity. Although to management these programs undoubtedly were well worth their cost, just as they are today, employees and their unions have always preferred wages and, from the earliest days, have met employer welfare programs with monumental disinterest (Chapters 3 and 4).

During World War II, when wage increases were "out for the duration," employees took the only thing they could get under government rules: fringe benefits—as the War Labor Board called them. More in-

terested in the reality of "something for the workers" than in theories, the union representatives on the tripartite War Labor Board did not object when employer and public members agreed to base the government's wartime policy on the employer's productivity-increase rationale —as long as that theory justified more, and more liberal, benefits (Chapter 5). After all, in their past experience, this had always been the purpose of employee benefits.

Before the war was over, however, employees did begin to show an interest in fringe benefits and theories (Chapter 6). The fringe benefits represented a large and a growing part of their collective bargains, and, having given up sizable wage increases for them, the unions protested when at employment termination a worker lost the benefits he had not yet taken. It was here and on the issue of paid vacations that the fallacious wage concept was born—to be spread not many years later to all fringe benefits. The battle for control of the fringe benefits, begun then, continued throughout the postwar period.

Immediately after the war, when freed from wartime wage restraints in 1946, the unions concentrated on a large wage increase at the bargaining table and sought their social gains in Congress. But this return to labor's traditional position was short-lived. Both their "inflationary" wage demands and their political action came under attack, and, by the second round of postwar negotiations, the unions were accepting "package" settlements that combined fringe benefits and a more modest wage rate increase. In securing themselves from attack, however, the unions had yielded the political power they needed to back up their economic power. Without the possibility of an alternative in legislated social gains, the unions had no choice but to succumb to the blandishments of employers who annually found certain fringe benefits far preferable to adding that same amount to wage rates.

* * *

Management still had its traditional reasons for pushing the employee benefit programs. The 1950's and 1960's were an echo of the 1920's as management described the miracles that social benefits could accomplish in making the work force more productive—provided, of course, that the employer kept firm control over the fringe benefit money and the conditions for eligibility to the benefit.

Another advantage to the employer of granting fringe benefits over wages arose from the postwar tax policies which led the way especially to the fringe benefits provided through trust funds. So generous were

the tax regulations (at a Treasury-estimated revenue loss of up to $3 billion a year) that if employers had not had their other sound reasons for staying close to the fringes, the tax advantage alone would have created a fringe benefit movement.

In addition, there was a new postwar advantage in fringe benefits over wages: employees whose social needs were met privately did not have to seek social gains through legislation. What employers saved in taxes to support such legislation could provide larger benefits when spread over only one's own employees, a fact that the employees and their unions also appreciated.

* * *

CHAPTER 1

The Problem: Are Fringe Benefits Wages?

* * *

Many of the social benefits which unions and liberal groups have failed to win in the form of legislation have been quietly but continually adopted privately by unions and employers in collective bargaining agreements. And employers, in the absence of unions, have been adopting many of these benefits voluntarily. For example, despite the failure of state unemployment insurance laws to come close to benefit standards proposed by both the Eisenhower and Kennedy-Johnson Administrations, this income gap has been closed for over two million workers by private supplementary unemployment benefit plans. Private pension plans to supplement Social Security benefits now cover an estimated twenty-six million workers. And, whereas Congress rejected national health insurance, private health and welfare plans now cover over a hundred million workers and their dependents.

* * *

In the last two decades, the fringe benefit movement has quietly transformed our concepts of the employer-employee relationship by its imposition of new, *social* obligations upon those who hire the service of others. But if this is a social revolution privately imposing a new kind of obligation upon employers, it is the best-kept secret of modern times. Both parties and all third parties take turns seeing who can deny it with the most convincing arguments.

The Confusion

Had this movement for fringe benefits been taking place through legislation, there would be little question of its social nature. But these benefits have come to workers as income from private employers. What, then, is the nature of this income? Is it part of the pay for their service? Is it wages? Or is it something to be called "non-wages"?

Those who use the term, non-wages, imply that there is a distinction between various forms of employee income payments. But when one looks for a basis for making such a distinction, he finds that no one is sure what either wages or non-wages is. Not the worker nor his employer, nor the economist, nor even the government agencies and other third parties who make decisions based upon the nature of this income can provide a consistent and unwavering distinction.

If you ask the worker himself what his non-wage benefits are, he will respond by enumerating various fringe benefits he receives at his work place. But then if you ask him what his weekly wages are, he will give you a figure which includes payments stemming from many of the non-wage benefits, such as pay for a holiday that fell during the week.

If you ask the economist, you find the same type of confusion. Although much has been written about wages and their function in the economy, there is very little in the literature about non-wage benefits and what these payments represent. The economist tends to lump all payments to labor together as wages. Some economists do speak of the growth of non-wage payments in reporting on various wage studies; but, after this use of the expression, they proceed to compare average weekly "wages," which include many fringe payments such as holiday and vacation pay, call-in pay, premiums of one kind or another. What does "non-wage" mean to them?

Sometimes wages refers to the employer's labor cost, at other times to the employee's income, though the two are not the same figure since the employer counts as labor costs certain items that are not income to the employee. It is not uncommon to find the labor economist using the word, wages, in one and the same study to mean labor cost, employee income, basic wage rates per hour, or wage rates plus some fringe benefit payments. Economists are aware of the problem, and some have called for enlightenment on this question, as, for example: "Clearly the many facets of non-wage compensation need

to be explored and integrated with wage theory and economic analysis."[1] But there have been too few responses.

Employers also have questions about these payments that are still unanswered. The U. S. Chamber of Commerce, in its 1957 study of fringe costs, noted:

> Differences of opinion regarding what constitutes fringe benefits and how they should be computed indicate the need for a generally accepted definition of fringe benefits, and for a uniform method of comparing fringe benefits with employee compensation.[2]

The legislators, too, who write and revise the many laws using the word wages, evidence the general lack of a clear meaning for the term.[3]

The problem is one both of understanding the nature of these payments and, then, of having useful definitions for the terms "wage" and "non-wage" that reflect that understanding.

Does it matter?

It matters very much where important decisions affecting workers income and welfare, and employers' costs and taxes, hang upon the question of what wages are and whether fringe benefits are wages or something else. Interpretations of the word, wages, determine eligibility to unemployment compensation benefits for millions of workers on layoff, or how much former workers of a bankrupt firm will receive, or what prevailing wage will be paid for work on government contracts. For the employer, the difference means higher or lower labor costs and taxes. Third parties in industrial relations—arbitrators and administrators of state and federal labor laws, as well as the courts called upon to uphold or reverse their decisions—need to know which payments are wages, which if any are non-wages, and why.

The word, wages, is defined or used in the Bankruptcy Act, the Labor-Management Relations Act, the Social Security Act, state un-

[1] Richard Lester, *As Unions Mature* (Princeton: Princeton University Press, 1958), p. 157.

[2] U.S. Chamber of Commerce, *Fringe Benefits 1957* (Washington: Chamber of Commerce of the U.S.A., 1958), p. 25.

[3] See, for example, U. S. Congress, House, Committee on Education and Labor, *Report on H.R. 10946, Amendments to the Davis-Bacon Act*, 87th Cong., 2nd sess., pp. 4, 5. The amendment reported proposed to include fringe benefits in the act's definition of wages, an amendment which became law in 1964. The committee called fringe benefits "much needed welfare programs" that are "bargained for, in lieu of wages," and therefore should be "included as wages...." But a few sentences later, the report says, "they now represent a very significant portion of wages" and then comments that the "worker receives his 'real' wages not only in the pay envelope after necessary deductions, but also in the form of these fringe benefits...."

employment insurance laws, and the Fair Labor Standards Act. The Bureau of Internal Revenue lives and breathes the word, wages. It is found also in the Davis-Bacon Act, the Walsh-Healey Public Contracts Act, and other laws both state and federal. As presently interpreted, however, the definitions of wages in these laws are in conflict with each other, sometimes even within a single state and under a single law.

* * *

Unable to get political support for social legislation, the unions sought their social gains in the only way open to them. The money which the long period of increasing productivity was making available for such gains did not lie in the tax revenue columns of the federal budget but in the profit columns of the companies the unions dealt with. Their social benefits were negotiated into private contracts.[2]

Social Obligations Privately Imposed on Industry

In these private contracts, workers secured from the very industries which most persistently opposed social legislation the same kind of obligation to provide social benefits that public measures would have fixed upon those industries.[3] The differences were differences only in extent, as a few comparisons will illustrate.

The Supreme Court decision that pensions were negotiable gave the stamp of approval to the unions' concept of employer responsibility for keeping former employees financially secure in their old age. It had already been recognized in the social security legislation, but on a shared basis for workers as a group and industry as a whole. The private pension plans imposed this same social obligation on individual employers for their individual workers and not always on a shared basis—the move for non-contributory pension plans places the obligation entirely upon the employer.

[2]This is not to say that these organized employers did not have some good reasons of their own for yielding to the private demands in preference to legislated social gains, as will be discussed later in this chapter and more fully in Chapter 10. Using their profits from the increasing productivity for their own employees was, of course, more advantageous to them than paying it in taxes for social benefits that would go to workers in other industries, particularly to those in low-productivity industries or even to the unemployed, with perhaps very few of their own relatively high-paid workers receiving any of the benefits directly.

[3]Of course, not all of the fringe benefits privately negotiated would have received public attention in any case. The comparison here is only with those which might have been legislated.

In the case of health and welfare plans, the privately negotiated benefits have established an industry social obligation, not yet imposed publicly (except for the elderly and very poor), to pay part of the costs of the illnesses of its individual workers. Workmen's compensation had previously fixed industry's responsibility for protecting its employees only from the economic hazard of job-connected injuries or illnesses. Supplementary unemployment benefits extend an industry obligation already publicly recognized.

Social in origin and in concept, the fringe benefit movement was being advanced in the postwar period by employees and their unions for the social benefit it provided. The demand for social benefits was strong enough to cause as long a strike as the 103-day UAW–Chrysler strike for pensions and legal actions pressed to the highest courts, as in the case of the Steelworkers for pensions.

Underlying the demand for social benefits was the growing belief that the employer had two obligations attendant upon his use of the workers' services: first, to compensate workers adequately for the actual service they rendered, at the rate of so much per hour; and then, beyond this, to assume certain obligations of a social nature essentially unrelated to production but existing because of the employment relationship. Those who hired the labor of others took on some social responsibilities pertaining to the needs of the man in his life off the job and in the society of which he was part.[4]

The social nature of fringe benefits becomes most apparent upon close examination of them.

Non-Wages to Provide Social Benefit

In examining these fringe benefit payments, our criterion is the *purpose* for the payment. To learn what the parties intended in negotiating them, we take first those payments which have most often been the result of employee or union demands. Later we shall consider labor cost items which the employer voluntarily incurs.

* * *

Time off

In the second category of social benefits are those which make provision for time away from work for some purpose that is social in nature without the worker's suffering loss of income because of his

absence. An employee asks for holidays because they are special historical or religious days that he wants to spend with his family, often engaging in community activities. An annual vacation is for the purpose of providing an extensive period away from work to recuperate from the preceding year's continuous service and to enjoy rest and recreation with his family and friends. Sick leave has the obvious social purpose, not only of enabling the worker to take proper care of himself without the financial loss to his family which otherwise occurs when illness disables the breadwinner, but also to enable him to stay home instead of exposing others during his illness. Time off for voting and for jury duty are other examples of provision of time off for social use. Personal leave of a given amount and absence from work when there is a death in the family also relate to the worker's life off the job and are thus social in nature.

It seems quite obvious that "regular wages" is usually provided in these payments, though often called wages for that reason, simply as the best way to effectuate their purpose of providing the time off without loss of regular income. A lump sum or average earnings or a figure calculated by some other method would do as well, provided it approximated customary income.

The fixed relationship between the amount of time off and the full year of service, such as eight holidays per year or so many days of sick leave or vacation time per year, merely expresses the agreed-upon concept of a normal or average need for such an allowance, i.e. the negotiated standard of the social benefit. Beyond setting the standard or extent of the benefit, the payment is quite unrelated to service. Jury duty, voting time, or sickness may or may not occur even though service is given. Thus, the payment may have some or no relation to service, depending upon what may be necessary to effectuate the purpose of the fringe.

There are certain periods of paid time off, often called fringe benefits, that do not have a social purpose and are, in fact, part of wages. The Chamber of Commerce and others list, in a category they call "pay for time not worked," such items as paid coffee breaks, meal periods, wash-up time, and travel time. Despite a superficial appearance that these payments are time-off provisions of the kind just described, they pertain to "on-the-job" conditions rather than to workers' more strictly social needs. Since the time off is in the form of short periods to enable the employee to rest briefly or perform some necessary function often related to or required by the work itself, but in any case now considered

necessary to the performance of each day's work, the time periods are more accurately to be considered "work" and their payment "wages."

Negotiation of pay for these on-the-job activities is simply part of the continuing process of redefining what constitutes "service" for which wages are to be paid. Certain minor activities that are not directly productive, from preparatory activities to visiting the rest room, have generally been considered as part of service covered by the basic rate per hour. The expanded concept of service may now include trips to the rest room, travel inside the plant portal to portal as well as from one machine to another during the day, wash-up time as well as time for checking out, sharpening or putting away tools. The difference is a matter of degree. Time-study men have seen many such changes over the years and, however they analyze and label the parts, have come to include as an allowance factor whatever is accepted by the parties as constituting paid service.

A distinction may be made between these and other part-of-a-day, time-off provisions such as those for jury duty or voting, which are not required by the work itself or in any way related to it but, rather, clearly provide time off the job for a social use. The regular hourly rate is paid in the one case because these breaks in productive work are part of "service" for which wages are to be paid and, in the other, because the worker is to be assured he may perform these off-the-job functions of a social nature without loss of customary income.

Protection against economic hazards

This third type of social benefit makes an outright payment to alleviate the economic hazards of illness, unemployment, old age, and the like. The non-wage, and social, character of this last group of fringes, sometimes extending benefits to cover a worker's dependents, is the most apparent. It is scarcely necessary to elaborate on their social nature and purpose beyond the mention in earlier pages of their similarities to legislated social benefits which they so closely parallel—even though all of these fringes at one time or another have been called wages.

The payments in this group also occur only as the social need for them arises, and they are paid according to the agreed-upon standard of how much economic hazard will be met with what level of benefits without reference to service rendered. The amount to be put into or paid out of funds established for these fringes, however, may have some relationship to service, but these decisions depend upon the social

purpose for which each fund was established. The amounts contributed to the funds are determined by the necessity to make the funds actuarially sound in order to meet a given and agreed-upon standard of benefits, i.e. in order to effectuate the social purpose of the benefit. Health and welfare, supplemental unemployment, and pension funds are neither invariably built up nor always paid out in relation to employees' past service. SUB funds might build up on this basis to a certain point after which payments into the fund are discontinued. All of the funds are drawn on by some employees but not by others, and by some to a different extent than by others. An employee, in fact, might live many working years and die without receiving a penny from any of the funds, though he may have worked under a contract providing all three of these social benefits.

In these respects, too, the fringe benefits of this third type differ little from their public counterparts. For example, in the case of social security benefits provided employees (in contrast to public assistance, or old-age assistance, provided others), the requirements of so many units of past work merely defines which employees are eligible for benefits and is like the minimum service requirement which exists in most private pension plans to determine eligibility. It may be raised or lowered in either case, depending upon what individuals the law or fringe benefit intends to cover.

Even the public benefits are expressed, in rough measure, in terms of earnings. They may seek to represent, as originally conceived, a percentage of average or normal earnings or they may reflect individual differences in past income level. The amount of the benefit, whether it is to be a minimum subsistence standard or to recognize a past standard of living or even perhaps to recognize financial obligations such as dependents, is also dictated by the specific social purpose.

If these non-wage fringe payments of the three types we have been discussing are negotiated by the unions to provide social benefits to the workers as a new kind of obligation of the employer, then for what purpose does the employer himself voluntarily make such payments in the absence of a union?

Non-Wages to Increase Work-Force Productivity

Under our "purpose" criterion for distinguishing between wages and non-wages, we must now ask why the employer makes the fringe payments and incurs the labor costs he does. Since not all labor cost items represent income to the employee, and yet an employer's total labor

cost is sometimes given as a definition of wages, we shall begin at this broadest point. Keeping to our same standard for what constitutes wages, we shall here, too, exclude those payments which all, including the employer, agree to be wages paid for the purpose of compensating for actual personal service rendered.

Setting aside for discussion shortly the payments of a social nature that we have just examined, let us consider the remaining labor cost items which employers customarily incur voluntarily and which unions only infrequently ask for in negotiations. These items generally do not represent income to the employee and are rarely called either fringe benefits or social benefits. They are considered labor overhead costs, frequently called or included in the term, employment costs. Although employers themselves differ as to what they would include, some of the more common are costs involving personnel administration, training, health and safety programs, a company doctor, nurse and sometimes counsellors, and in some cases (where not understood and agreed to be part of payment for service) special employee gratuities, bonuses, and privileges such as discounts, passes, meals, prizes and awards, ball teams, clubrooms, and other recreational facilities.

These labor costs are clearly non-wage in nature. They are not compensation for actual service, even where they may represent income to the employee directly or indirectly. Their purpose is to maintain an efficient work force in operation, as in the case of the personnel costs, or to increase employee productivity more specifically, as in the case of training and safety programs.

It will be noticed that these costs for the most part pertain to the needs of employees on the job, in contrast to the costs in the social benefit groups, which pertain generally to off-the-job and more strictly social costs. A company doctor and nurse, for example, may care for illnesses that arise or that become acute on the job; sick leave or health and welfare plans, sometimes covering dependents, pertain to off-the-job illnesses.

This distinction is not a hard and fast one, however. A number of the labor overhead costs for the purpose of maintaining an efficient work force may be social in nature, as in the case of recreational facilities for use off the job, counseling programs, and the like.

But their social nature does not change the fact that the employer incurs the cost to increase productivity. Quite the contrary. *He is particularly interested in them precisely because of their social effects.* The employee who can stay home and take care of his cold because he has

a sick leave plan returns to work with more energy and without having exposed his fellow workers in the meantime. Other fringes have similar advantages, and, in general, the greater freedom from insecurity and worry about the financial problems of old age, unemployment, catastrophic illness, or accidents is felt by some employers to affect production favorably. Fringe benefits, particularly those that require employees to build up seniority in order to be eligible for them, are adopted to keep, or to attract, labor—in other words, for the purpose indirectly of increasing productivity by reducing turnover costs.

Others envision improvements in morale and loyality to result from the voluntary provision of fringe benefits. Seeking out new parts of the whole man is a time-honored effort to increase productivity. Paternalism is an ancient word in industrial relations, and company social welfare programs have a long history. Ever since industrial psychology became fashionable, the adventures of counseling programs have been famous and their miracles often described in the industrial relations literature. Or the granting of social benefits which unions have won elsewhere is thought useful by some in persuading workers that having a union in the plant is not necessary.

There are still other advantages to the employer in fringe benefits. From most fringes the employer receives a specific quid pro quo, as in the case of severance payments, which relieve the employer of all further responsibility to the employee, or in-lieu-of-notice, reporting, or other premium payments which free the employer to exercise greater flexibility in work planning without stirring up resentments among his employees.

All these advantages of fringe benefits (and others discussed in Chapter 10) enable the employer to increase the over-all productivity of his work force and are more or less closely calculated in the decision to grant one benefit or another.

Having taken all labor costs—in order to test the validity of our basic wage and non-wage distinction—and classified them (chart, p. 36) by our criterion of seeking the purpose of the payment or cost, according to the party initiating the action for it, we must also recognize that where the union is involved there may be an area of mutual advantage. A bargain is struck, and who is to say how much results from the employees' desire for the benefit and how much from a compensating benefit the employer sees accruing to himself? We can say only that fringes which are union-initiated are for the *primary* purpose of providing the particular social benefit as such, while in fringes initiated

by the employer, the provision of social benefit is a *secondary*, though essential, consideration. His primary purpose in voluntarily incurring the cost is to increase work-force productivity directly or indirectly.[7]

Chart. Common Labor Costs Classified by Purpose

Classification	*Purpose of Labor Cost as Intended by Initiator*
Wages	To pay for actual service rendered: Hourly rate, piece rate, incentive earnings, production bonuses, commissions, other payments in money or kind based directly or indirectly upon production or productive service and understood and agreed to be payment for that service.[8]
Non-Wages	1. To provide social benefit as such: a. Penalty-premiums: overtime, night-shift differentials, Sunday and holiday work premiums, vacation pay in lieu of vacation, reporting or call-in pay, in-lieu-of-notice payments. b. Time off: vacations, holidays, sick leave, voting time, jury duty, funeral leave, maternity leave. c. Economic-hazard protections: health and welfare plans, pensions, SUB, life insurance, severance and other dismissal payments; also unemployment insurance, workmen's compensation, and OASDI.
Non-Wages	2. To increase productivity of the labor force: a. Social benefits listed above when voluntarily provided by the employer. b. Personnel administration, training, health and safety programs, company doctor, nurse, counsellors and equipment, special employee gratuities, bonuses, and privileges such as discounts, passes, ball teams, other recreational facilities, prizes, and awards.

[7]An exception to the text above which should be noted here is the employer who, out of a genuine social sense and concern for his fellow in whatever relationship, voluntarily incurs the cost of a social benefit solely or primarily for its benefit to the employee. This is particularly true in small firms where he knows his employees best. There is also the occasional union which has sought social benefits primarily

When the states emphasized the social purpose of SUB, however, they described all fringe benefits the best. Missouri, for instance, said of SUB:

> The features of the Plan appear to be quite in keeping with the aforementioned public policy. Certainly such supplemented benefits are no less for the public good and the general welfare of the people of this state when voluntarily provided by contract than when provided by the state. . . .[10]

In saying this, it was suggesting standards by which all fringe benefits might be considered non-wage payments. Health and welfare plans, paid vacations, and others certainly are "no less for the public good and the general welfare of the people." Paid holidays to free working people to celebrate the American Revolution and other historical and religious days together with the community could be held a laudable purpose. Certainly the various types of dismissal payments, like SUB and unemployment compensation, enable the worker to be more mobile in seeking other employment; and any fringe benefit adds to purchasing power at a time when it is needed. Sick leave and sickness benefits that raise the health level of the country could be found to deserve as much encouragement as private benefits that supplement legislation already in existence. This was especially true if, as was often said in SUB cases, private provision for economic hazards was to be encouraged "to meet the needs of our people." If SUB was non-wages because it voluntarily provided by contract what legislation had determined was public policy, then pensions, too, could be non-wages as they supplement and implement public policy expressed in the Social Security legislation.

Scarcely a fringe benefit exists that could not have been included in Montana's gratification that "big business will concern itself with the security of its employees and their families" and "assist workers to insure themselves against hazards of many kinds" and that "business and labor together can preserve the dignity of the worker in his job."

* * *

Similarly, sick leave plans showed no change in qualifying conditions from 1958 to 1966, but coverage shifted to trusteed plans where more employees received better coverage.[11] The earned right idea of paying for unused sick leave was nowhere in evidence—unless it came from management which occasionally suggested that it buy back unused sick leave at a reduced rate, which would save money over having employees take the time when not ill.[12]

PLAINTIFFS' EXHIBIT NO. 85
Social Security Programs Throughout The World,
1971, U.S. Dept. of HEW.

DISCRIPTION OF PROGRAMS

THIS RESEARCH REPORT highlights the principal features of social security systems in all countries having such systems. Only fully independent countries are covered; other jurisdictions have been excluded because of space limitations. The report includes information for 125 nations—two more than in the last edition published for 1969. Each of these has enacted statutes concerning at least one of the main social security branches.

The data reported here reflect the status of the various national social security systems at the beginning of 1971.

* * *

FORMAT OF COUNTRY SUMMARIES

The information on national social security systems is presented here in the form of a tabular summary for each country. All charts extend across two pages and are organized identically. They contain eight vertical columns with the same headings for all countries, and five horizontal rows corresponding to the major social security branches.

* * *

Horizontal rows.—Wherever one of these rows which correspond to the five main branches of social security has been left blank, it signifies that the country in question does not have a program in force for the branch concerned.

The top row of each country chart covers programs concerned with the contingencies of *old age, invalidity, and*

death. Benefits provided upon the occurrence of these risks ordinarily take the form of pensions payable for life, or at least for a considerable number of years; hence they are usually referred to as benefits for "long-term risks." Ordinarily, these programs are administered jointly and have a pooled source of financing as well as interrelated qualifying conditions and benefit formulas. It is therefore logical to group them together.

* * *

The second type of long-term risk for which pensions are provided under social security programs is invalidity. This may be generally defined as permanent or long-continuing and more or less total disablement resulting from a nonoccupational injury or disease. (Disability caused by a work injury or occupational disease is usually compensated under separate benefit programs or provisions, rather than under the general invalidity provisions; these benefits are dealt with in the third row of each summary.) The third type of pensions listed in the top row are those payable to dependents of insured workers or pensioners who die. Pensions for survivors of work-accident victims are usually provided under separate programs.

The second row of each country summary deals with programs concerning the risks of *sickness and maternity*. Programs covered include those providing one or more of the following: (1) cash benefits to replace wages lost as a result of relatively short-term sickness of nonoccupational origin, (2) cash benefits to replace wages lost during maternity leave, and (3) medical benefits or services provided in the event of either of these contingencies. Again, the cash benefits and medical care provided during the temporary disability resulting from a work injury or occupational disease are not dealt with in this row, but in the third.

One reason for grouping in a single branch the several kinds of benefits shown together in the second row is that each deals in one way or another with the risk of temporary incapacity. Moreover, in most countries where such benefits are provided, all of them are usually furnished as part of a single system with common financing and administration. The majority of countries provide medical-care services for sickness and maternity as an integral part of their sickness insurance system, and link such benefits directly with the provision of cash benefits. In a few countries, however, medical-care services are provided under a public service program independent of the social insurance system. Where this dual approach is followed, it has been indicated in the summaries.

* * *

MEASURES COVERED BY REPORT

The individual countries may differ considerably in the programs they classify under the term "social security." To ensure intercountry comparability in this survey, it is necessary to single out those fundamental elements which such programs have in common. The characteristics used in deciding upon the programs to be included in this report are summarized below.

One principal characteristic of social security programs is that they are established by governmental statute. This is true whether or not their actual administration is entirely in public hands.

A second characteristic of the social security measures included in this study is that they usually provide some kind of cash payments to individuals to replace at least part of the loss or deficiency in their income caused by

such long or short-term contingencies as old age, invalidity, and death; sickness or maternity; work injury; and unemployment. Programs that provide regular cash allowances to families for the maintenance of children are also regarded as social security programs. Finally, statutory programs that provide medical treatment to individuals (other than traditional public-health services), or that are concerned with financing such curative services, are usually considered to be a form of social security in countries where they exist.

* * *

Social insurance.—One major element of most social insurance programs is that they are financed entirely or largely from special contributions paid by employers or employees, or both, rather than entirely from ordinary government revenues. These contributions are usually placed in a fund kept separate from other government accounts, and all benefits are paid in turn from this fund. The rights of individuals to benefits under social insurance ordinarily are either derived from or linked in some way with their contributions or coverage under the program. Benefit amounts under most social insurance programs also vary among beneficiaries according to their prior earnings. Such amounts are rarely adjusted to either the current means or needs of individual recipients.

Most social insurance programs are compulsory. This means that expressly defined categories of workers and their employers are required by law to register, pay contributions and otherwise participate in the system. Qualifying conditions and benefit formulas are nearly always prescribed in the statutes, leaving little if any room for administrative discretion in awarding benefits. There are

statutory programs in a few countries, however, under which the participation of employers and perhaps that of workers is voluntary or at least quasi-voluntary. A substantial subsidy is often granted by the government to such voluntary programs to stimulate broad participation.

Most social security provisions in force around the world today are actually of the social insurance type. They are also compulsory in their application. Thus, a large part of the material presented here concerns compulsory social insurance measures.

* * *

The following tabulation shows the number of countries included in the 1940, 1949, 1958, and 1971 Social Security Administration studies as having some type of social security program:

	1940	1949	1958	1971
Any type of program	57	58	80	125
Old age, invalidity, survivors	33	44	58	101
Sickness and maternity	24	36	59	68
Work injury	57	57	77	122
Unemployment	21	22	26	34
Family allowances	7	27	38	63

* * *

Coverage.—Wide differences exist in the proportion of the population covered by the sickness and maternity programs of various countries. These differences are correlated to a considerable degree with the economic development of the countries. Coverage is usually fairly extensive in the industrialized countries, but tends to be quite limited in countries still in the early stages of economic development. During the past decade, public health schemes in a

number of developed countries have greatly increased the percentage of people covered. Notable examples are France and Italy.

Wage earners aare vulnerable to the risk of income loss from sickness or maternity. Self-employed persons have traditionally been considered to be subject to this risk to a much lesser extent, and it does not really exist at all for persons not gainfully employed. Only a few countries cover self-employed persons for cash sickness benefits, due in part to the difficulty of verifying their actual loss of income when they become ill. As a result the coverage of nearly all of the cash benefit programs dealt with in the second row of the country summaries is limited primarily to employees in general or to particular classes of employees. A number of the newer systems apply only to employees of larger firms in industry and commerce or, as in India, only to those in the larger factories. These programs exclude virtually the entire agricultural population of the countries concerned, which in some may comprise more than 80 or 90 percent of the whole population. Some higher paid employees are excluded from sickness insurance in a few countries of Europe, e.g., the Federal Republic of Germany and the Netherlands.

* * *

Qualifying conditions.—Nearly all sickness and maternity programs provide for the payment of cash sickness or "temporary disability" benefits to insured employees who are prevented from working because of an illness or non-occupational injury. To be eligible for such payments, a worker must have suffered a wage loss. Specifically, he must be incapacitated for work and not be receiving his regular wages or sick leave payments from his employer. And he must usually furnish some kind of medical certification of his inability to work.

Besides being incapacitated for work, most sickness and maternity benefit programs require claimants for cash benefits to meet some kind of minimum qualifying period of contribution or employment. As a result, cash benefits are restricted to persons who regularly derive their livelihood from employment and who consequently suffer a genuine loss of earnings when they are ill. Further, the qualifying conditions help to secure a reasonable balance between program expenditures and revenues.

Comparison of the summaries (fourth column, second row) shows that the length of the qualifying period for cash sickness benefits differs considerably from country to country. It ranges from 1 month to 6 months or more and must usually have been served fairly recently, such as during the last 6 or 12 months immediately preceding the claim. The qualifying period for cash maternity benefits is ordinarily somewhat longer than that for sickness benefits. It is often fixed at 10 months of contribution or employment during the last 1 or 2 years preceding the expected date of confinement.

The qualifying period for medical benefits under some social insurance systems is the same as that for cash benefits. In this case, a worker acquires and retains eligibility for both types of benefits during the same period. Other systems require a somewhat shorter qualifying period for medical than for cash benefits. Many have no qualifying period at all for medical benefits and thus, in effect, provide them to any worker currently in insured employment. No qualifying period is required in those countries where medical care is furnished as a public service.

Most programs providing medical services to dependents of workers as well as to the workers themselves do not distinguish in their qualifying conditions between the two types

of beneficiaries. A few of them, however, require longer periods of insured employment for dependents before medical services are provided to them.

Cash benefits.—Countries commonly fix the benefit formula for cash sickness benefits at 50-75 percent of the worker's average earnings during the preceding few months. Payment of benefits at a rate less than full wages furnishes an incentive to workers who are ill to return to work as soon as possible rather than to continue drawing benefits, and thus discourages malingering. Beneficiaries supporting a wife or children are frequently paid supplements to their basic benefit. Most programs either expressly fix a maximum benefit amount, or do so indirectly through a general ceiling on earnings for contribution and benefit purposes. Benefit rates are reduced in a number of countries when beneficiaries are hospitalized at the expense of the social insurance system, but the reduction is always smaller for beneficiaries with dependents than for single persons.

A 2-7 day waiting period for cash sickness benefits is imposed under most programs. This means that no benefit is payable if a disabling illness lasts only a few days and that the first few days are not compensable in case of long illnesses. Under some programs, benefits are retroactively paid for the waiting period when the disability continues beyond a specified time, commonly 2 or 3 weeeks. The imposition of a waiting period serves to reduce both administrative and benefit costs of sickness insurance programs by excluding many claims for short illnesses during which a workers's income-loss is relatively small.

Cash sickness benefits are usually paid on a weekly basis, although they may be computed on another basis. The aggregate number of weeks during which a worker may receive

benefits for a single spell of sickness, or in a given year, is ordinarily limited by a statutory maximum. The summaries suggest that the most common limit is 26 weeks. In some countries, however, benefits may be drawn for a considerably longer period, or even for an unlimited duration (e.g., Sweden and United Kingdom). A number of countries permit the administering agency to extend the usual maximum to perhaps 39 or 52 weeks in individual cases (such as when recovery from the illness seems probable within the period of extension, or for infectious diseases). After cash sickness benefits are exhausted, they are converted in most countries into invalidity pensions if it is then apparent that the recipient will continue to be incapacitated either permanently or for a long period.

Cash benefits are also payable in the great majority of countries for a specified period of time before and after childbirth to working women covered under insurance. Prerequisites of such maternity benefits nearly always are that the woman abstains from paid employment while receiving benefits; that her employer is not continuing her wages and she is sustaining an actual income loss; and usually that she is using the prenatal and postnatal medical services provided by the system. The percent of earnings payable as a cash maternity benefit differs considerably from country to country, ranging from 50 to 100 percent of wages. Benefit payments usually start approximately 6 weeks before the expected date of confinement, and end 6 or 8 weeks after confinement.

Several countries provide a special nursing allowance in addition to the basic cash maternity benefit. This allowance normally amounts to 20 or 25 percent of the regular maternity benefit and may be payable for up to 6 months or longer. A grant for the purchase of a layette, or a layette itself, is furnished under some programs. Finally, a substantial lump-

sum "maternity grant" is paid in some countries upon the birth of each child. Not only insured women but also the wives of insured men are often eligible for this lump-sum payment. Similar birth grants are paid in some countries under the family allowance program (fifth column, bottom row, of the summaries).

Medical benefits.—The great majority of social security programs providing sickness and maternity cash benefits also provide medical benefits or services. The rationale of providing these two kinds of benefits is that the cost of medical care imposes a severe financial burden on a sick worker in much the same way as does his loss of wages. Another consideration is that the cost of providing cash sickness benefits to a worker who is ill will be lower the earlier that curative care enables him to return to work.

The particular types of medical services provided under social security programs vary somewhat from country to country. They usually include at least general practioner care, some hospitalization, and essential medicines. The services of specialists, limited or broader dental care, a wider range of medicines, and perhaps certain appliances are often added. And finally, transportation of patients, and home-nursing services may be included.

* * *

Maternity care for working women covered by the social security system is provided in most countries under the program that provides medical services generally. Normally, prenatal, obstetric, and postnatal care are included. Obstetric care is sometimes limited to the services of a midwife, although those of a doctor are usually available in case of complications. Care in a maternity home or hospital as well as essential medicines is ordinarily furnished where necessary. The method

used in each country for providing medical services generally—whether the service-benefit, reimbursement, or direct-provision method—is usually followed also in the provision of maternity care.

Medical care for dependents.—Countries providing medical benefits for insured workers through social insurance typically furnish similar services to their dependents. The latter usually include the spouse and young children (sometimes other adult or young relatives living with the insured and dependent upon him). Services available to dependents in some countries, however, are more limited than those provided to insured workers or family heads. The maximum duration of hospitalization, for example, may be briefer for dependent, or a larger percent of the cost of certain services such as medicines may be payable by the patient if the latter is a dependent. Medical care in case of maternity is generally provided to the wife of an insured man.

* * *

Administrative organization.—Patterns of administrative organization for sickness and maternity programs are generally similar to those for old age, invalidity, and survivors. Most commonly, such programs are administered by some form of quasi-autonomous national social insurance institution. These institutions are established by law and subject to general supervision by a government minister. They are usually managed by boards composed of representatives of insured workers, employers, and the government, and operate with a considerable degree of independence. This type of organization is particularly common in Latin American and Asian countries.

Some institutions own and operate their own medical establishments which furnish at least part of the services available under their programs. Direct contacts with insured

persons and providers of services in some countries are handled by regional and local branches of the national agency.

In several other countries, responsibility for most of the detailed administration of sickness insurance is placed in the hands of nongovernmental sickness funds or societies of various types. This is the case, for example, in Austria, Belgium, Denmark, Federal Republic of Germany, Luxembourg, Netherlands, and Switzerland, and to some extent in Australia and Japan. These funds serve, in effect, as administrative agents for the government in handling direct contacts with insured persons and providers of health services. All workers covered by the social insurance program are required to join one of the funds.

Each fund must usually be approved by the government before it can operate, and must satisfy certain minimum requirements specified in the law before receiving approval. The funds also continue to be subject to some governmental supervision. Their jurisdiction may be limited to a single city or district, or to a particular occupation. In some countries, the funds number several hundred or even more than a thousand.

* * *

In most of the remaining countries, representing a minority of the total, government departments are responsible for the actual provision of sickness and maternity benefits, including in some cases medical services. This administrative responsibility is often linked with that for other types of social security benefits, the entire range of benefits being administered as a single program. Examples of countries with exclusively governmental administration of health insurance are the United Kingdom, Ireland, and New Zealand.

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PLAINTIFFS' EXHIBIT NO. 86
Physician Service Patterns and Illness Rates, Helen Hershfield Avnet (Group Health, Inc.).

Physician Service Patterns and Illness Rates

Helen Hershfield Avnet

A Research Report on Medical Data Retrieved from Insurance Records

Group Health Insurance, Inc.

PREFACE

This study was undertaken by Group Health Insurance (GHI) to demonstrate the wealth of medically relevant data which can be produced as a by-product of medical insurance administration.

* * *

Without repeating what is already in the body of the Report, the unprecedented variety of subjects treated specifically or by implication is illustrated in this section of questions based on the contents:

* * *

How would reporting of annual incidence rates of each diagnosis, surgical or diagnostic procedure and other correlated treatment data for age-sex subgroups, provide a more equitable base for comparing and evaluating care under different systems of medical care distribution?

* * *

This volume is the third original research report to be published by GHI-GHDI in five years. Like its predecessors ("Psychiatric Insurance" and "Insured Dental Care") it is distributed as a community service. We hope that by showing what can be done as a first step by one organization, we shall be helping to stimulate further action in this sphere, by those in strategically appropriate positions, toward our common ultimate goal of improved medical care distribution.

George W. Melcher, Jr. M.D.
President, Group Health Insurance, Inc.

Chapter 16
DISTRIBUTION AND INCIDENCE OF ATTENDED ILLNESS

Diagnoses entered on claim forms by treating physicians have been analyzed in conjunction with demographic and treatment variables. The first type of analysis, relating illness data to the population at risk, results in the derivation of morbidity rates, discussed below. The second approach, coordinating treatment with diagnosis on a case basis, is presented in the following chapter.

* * *

Furthermore, as a regular source of data not requiring special collection efforts, insurance records have advantages with respect to lower costs, which should be a plus factor of some weight in arranging for eventual annual or biannual morbidity indices. As for accuracy of terminology, reliance on physicians for reports of diagnosis, whatever the shortcomings, is clearly preferable to consumer impressions of ailments as interpreted by household interviewers. Perfection of source material cannot be a prerequisite for compilation of needed data. In this connection it should be recalled that entries by physicians on death certificates are deemed the likeliest assurance of accuracy and are accepted for compilation of mortality statistics, even though some degree of incorrect, inconsistent, or unstandardized cause-of-death labeling, of unknown extent, must be assumed. The same will always be true of morbidity reporting.

In addition to its records of physician-reported diagnoses, population characteristics and treatment patterns, GHI's advantages as a collector of morbidity data stem from its type of organization and coverage: the fact that

it operates within the still-predominating free-choice fee-per-service framework removes the need to consider the possible influence of this factor (except for special comparative studies); while its provision of comprehensive coverage permits an integrated presentation of combined ambulatory-hospital experience. Morbidity studies confined to hospitalized illness can be helpful in evaluating and comparing hospital utilization, but ambulatory patients' diagnoses comprise the bulk of conditions demanding physicians' services. (See Table 126 for diagnostic comparison of hospital illness and all illness.) Similarly, the inclusion of all reported incidence in one analysis (as opposed to the separation of "chronic" and "acute" conditions), together with subsequent analysis relating treatment to diagnosis, helps to develop an integrated picture of the "whys" of the medical care detailed in previous chapters.

TABLE 126. All Diagnoses vs. Hospital Admissions: Comparison of Diagnostic Distributions

CATEGORY	PER CENT OF REPORTED DIAGNOSES	
	All Cases	*Hospital Admissions*
TOTAL	100.0	100.0
Infective and Parasitic Diseases	5.8	.8
Neoplasms	1.9	9.2
Malignant Neoplasms	.4	2.8
Allergic, Endocrine System, Metabolic and Nutritional Diseases	5.0	2.7
Diseases of Blood and Blood-Forming Organs	.7	.5
Mental, Psychoneurotic and Personality Disorders	.4	.5
Diseases of Nervous System	1.2	1.9
Diseases of the Eye	2.6	2.0
Diseases of the Ear	3.8	1.1
Diseases of the Circulatory System	5.2	10.1
Heart Diseases	1.9	5.2
Diseases of the Respiratory System	29.4	13.1

Diseases of the Digestive System	7.0	14.8
Diseases of the Urinary System	1.5	3.6
Diseases of the Male Genital Organs	.4	1.5
Diseases of the Female Genital Organs and Breast	3.2	5.2
Deliveries and Complications of Pregnancy, Childbirth and Puerperium	1.0	17.1
Diseases of Skin and Subcutaneous Tissues	6.0	1.9
Diseases of Bones and Organs of Movement	4.3	3.1
Injuries and Adverse Effects of External Causes	8.3	7.3
Symptoms, Senility and Ill-Defined Conditions	3.5	2.4
Preventive Care	8.6	0
Other (Congenital Malformations and Certain Diseases of Early Infancy)	.2	1.2

Notes on Methods of Classification and Analysis

In classifying physicians' diagnostic entries retrieved from claim forms, twenty-three categories have been used, including separate categories for eye conditions, ear conditions, one for "undetermined" and one for "supplementary"—the latter generally indicating preventive care rather than a diagnosis of illness. Except for these few modifications, the classification system follows that of the "International Classification of Diseases".

* * *

Most and Least Frequent Entries

Inspection of incidence rates of individually listed disorders (as opposed to disease categories) brings into quick focus the relative infrequency of some of the more dramatic, disabling or lethal disorders and the comparatively routine nature of many of those most frequently reported—the latter reflecting, of course, the

inclusion of diagnoses rendered in connection with office or home visits (Table 127).

Of the 38 diagnoses listed among the most frequent, 20 affected 2 or more per cent of the population, and 18 affected between 1.0 and 1.9 per cent. This list is dominated by acute conditions but includes exceptions such as arthritis, arteriosclerotic heart disease, diabetes, ul ulcer—each reported for 1 to 3 per cent of the population.

* * *

TABLE 127. Selected Incidence Rates, Most and Least Frequent Diagnoses Listed

CASES REPORTED PER 1000 EXPOSURE YEARS (ADJUSTED TO AGE-SEX COMPOSITION OF GENERAL POPULATION)			
Most Frequent *			
Pharyngitis	113.8	Cellulitis	20.3
Bronchitis	87.7	German Measles	19.1
Gastroenteritis-Colitis	54.7	Myositis	17.8
Tonsillitis	52.9	Laryngitis	17.7
Sprain-Strain	47.9	Hay Fever	16.7
Otitis Media	42.8	Cystitis	16.3
Intestinal Virus	40.4	"Strep Throat"	15.2
Arthritis	30.3	Cervicitis	15.2
Dermatitis	29.8	Fracture	14.3
Influenza	29.8	Asthma	14.1
Laceration	29.7	Menstrual Disorder	14.0
Benign Neoplasm	29.5	Anemia	13.8
Synovitis-Bursitis	28.2	Arteriosclerotic Heart Disease	13.2
Obesity	25.2	Diabetes	12.9
Contusion(s)	24.3	Hemorrhoids	11.9
Sinusitis	22.5	Pneumonia	11.6
Conjunctivitis	22.4	Vaginitis	11.3
Gastritis-Duodenitis	21.9	Ulcers	11.1
Normal Delivery	20.6	Head Injury	10.1
Least Frequent †			
Muscular Dystrophy	.1	Nephritis-Nephrosis	.9
Hodgkin's Disease	.1	Scoliosis	1.1
Ectopic Pregnancy	.1	General Arteriosclerosis	2.3
Leukemia	.2	Abortion	2.6
Pulmonary Embolism	.2	Cataract	3.7
Infectious Hepatitis	.3	Glaucoma	4.0
Multiple Sclerosis	.3	Acute Coronary Occlusion	4.5
Retinal Detachment	.3	Malignant Neoplasm	8.6
Complicated Delivery	.4		

* Ten or more cases per 1000 exposure years.

† Diseases occurring at a rate of less than 1 case per 10,000 exposure years were not tabulated separately.

TABLE 128. Distribution of Attended Illness by First Month of Service, by Diagnostic Category

Part I: to June

DIAGNOSTIC CATEGORY	Total	FIRST MONTH OF SERVICE: January	February	March	April	May	June
	%	%	%	%	%	%	%
Infective and Parasitic Diseases	100.0	10.5	10.7	14.0	11.5	9.2	8.0
Neoplasms	100.0	9.1	8.8	9.1	9.1	9.8	8.8
Allergic, Endocrine System, Metabolic and Nutritional Diseases	100.0	11.5	7.9	9.5	10.5	10.3	9.1
Diseases of Blood and Blood-Forming Organs	100.0	10.7	6.6	6.3	9.4	13.0	11.5
Mental, Psychoneurotic and Personality Disorders	100.0	13.9	7.0	7.2	9.4	4.9	9.7
Diseases of Nervous System	100.0	8.1	8.8	8.8	11.2	8.4	9.0
Diseases of the Eye	100.0	8.5	5.9	8.2	8.7	8.6	9.4
Diseases of the Ear	100.0	9.3	8.5	9.9	8.4	10.0	8.5
Diseases of the Circulatory System	100.0	8.8	8.9	8.9	9.2	8.9	8.4
Diseases of the Respiratory System	100.0	10.0	10.2	9.7	8.8	7.7	6.4
Diseases of the Digestive System	100.0	10.1	8.2	8.2	8.8	6.7	7.7
Diseases of the Urinary System	100.0	8.2	6.9	10.8	8.7	9.7	7.8
Diseases of the Male Genital Organs	100.0	11.6	4.9	9.2	10.1	8.5	7.2
Diseases of the Female Genital Organs	100.0	9.2	7.1	8.7	9.3	9.0	8.9
Deliveries and Complications of Pregnancy, Childbirth and Puerperium	100.0	9.1	7.7	7.5	8.6	8.5	8.0
Diseases of Skin and Subcutaneous Tissues	100.0	8.9	8.7	7.9	8.3	9.1	10.0
Diseases of Bones and Organs of Movement	100.0	7.7	8.5	8.5	9.5	9.9	8.7
Congenital Malformations	100.0	8.8	8.8	4.4	9.4	8.5	8.8
Diseases of Early Infancy	100.0	12.9	13.9	4.9	3.0	5.9	10.9
Symptoms, Senility and Ill-Defined Conditions	100.0	8.6	9.0	8.2	8.9	9.8	8.3
Injuries and Adverse Effects of External Causes	100.0	7.1	6.6	7.8	7.9	9.2	8.9
Supplementary Classifications (General Medical Examination, Well Baby Care)	100.0	7.0	7.6	6.8	8.8	8.0	9.4
Undetermined Classifications	100.0	10.4	8.8	10.4	8.5	8.6	8.1
TOTAL	100.0	9.3	8.6	9.1	9.1	8.8	8.0
TOTAL EXCLUDING UNDETERMINED CLASSIFICATIONS	100.0	9.3	8.6	9.0	9.1	8.8	8.0

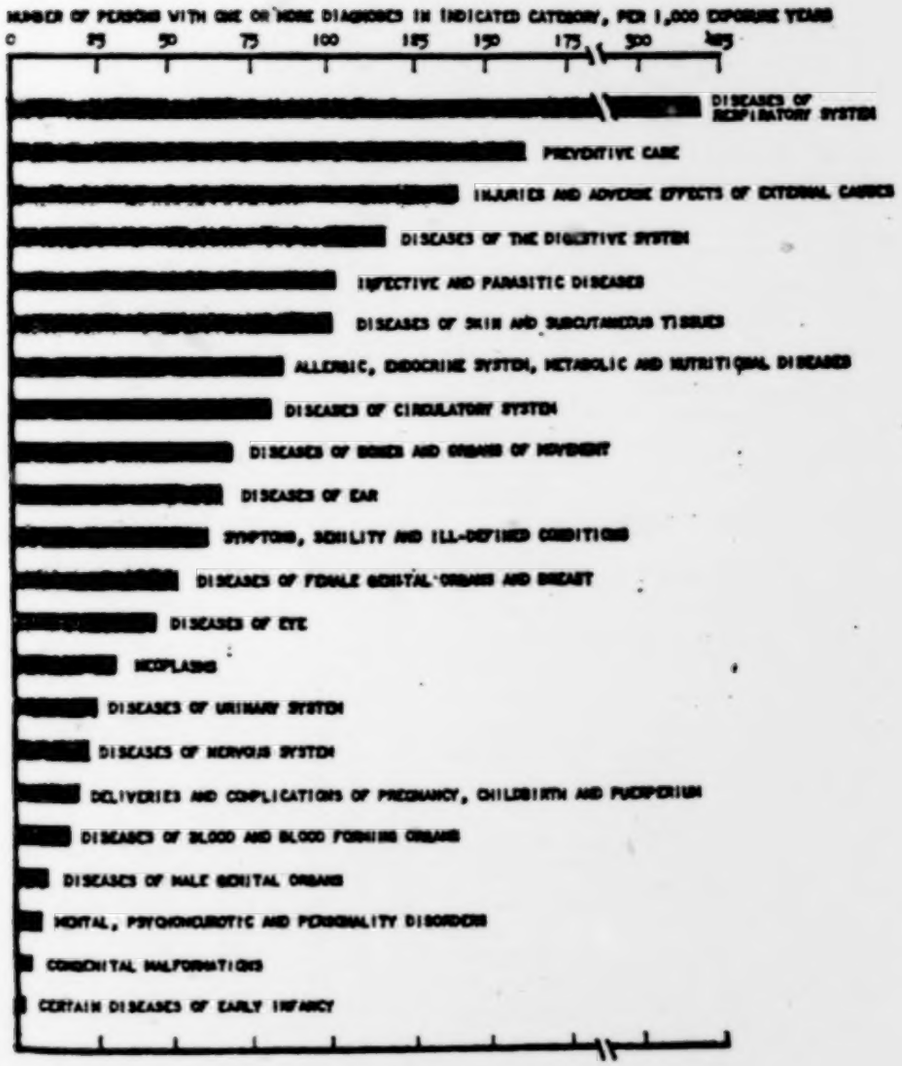
Part II: July to December

DIAGNOSTIC CATEGORY	FIRST MONTH OF SERVICE: July	August	September	October	November	December
	%	%	%	%	%	%
Infective and Parasitic Diseases	4.7	5.5	6.4	6.2	7.6	7.7
Neoplasms	7.2	7.3	8.6	8.2	7.2	9.0
Allergic, Endocrine System, Metabolic and Nutritional Diseases	6.3	6.8	7.2	7.9	6.8	6.0
Diseases of Blood and Blood Forming Organs	5.9	5.1	8.4	9.8	7.8	5.9
Mental, Psychoneurotic and Personality Disorders	7.2	7.3	11.1	7.3	7.8	7.2
Diseases of Nervous System	10.0	7.2	7.5	8.1	8.3	6.6
Diseases of the Eye	8.2	6.6	9.4	10.2	8.3	9.0
Diseases of the Ear	9.4	7.2	7.3	7.7	7.2	6.6
Diseases of the Circulatory System	7.7	7.8	7.6	9.2	8.0	6.6
Diseases of the Respiratory System	4.8	6.2	7.8	9.8	9.2	9.4
Diseases of the Digestive System	7.7	7.8	8.4	8.7	8.5	7.2
Diseases of the Urinary System	6.2	7.6	8.3	11.7	6.8	7.3
Diseases of the Male Genital Organs	8.4	11.6	8.2	8.5	6.8	7.0
Diseases of the Female Genital Organs	7.8	7.3	8.1	9.6	8.8	6.2
Deliveries and Complications of Pregnancy, Childbirth and Puerperium	8.6	7.7	7.6	9.8	9.6	9.3
Diseases of Skin and Subcutaneous Tissues	8.5	8.8	8.8	7.9	8.9	8.2
Diseases of Bones and Organs of Movement	8.6	7.7	8.1	10.0	7.6	7.2
Congenital Malformations	8.2	4.1	11.8	13.3	6.5	7.4
Diseases of Early Infancy	3.9	7.9	7.9	13.9	4.0	10.9
Symptoms, Senility and Ill-Defined Conditions	7.4	6.6	7.0	9.4	9.2	7.6
Injuries and Adverse Effects of External Causes	9.7	8.9	9.3	9.1	7.9	7.6
Supplementary Classifications (General Medical Examination, Well Baby Care)	6.9	9.4	9.4	10.0	11.2	8.5
Undetermined Classifications	6.3	6.7	7.0	9.2	8.1	7.9
TOTAL	6.8	7.3	8.0	9.1	8.4	7.5
TOTAL EXCLUDING UNDETERMINED CLASSIFICATIONS	6.9	7.4	8.1	9.1	8.4	7.4

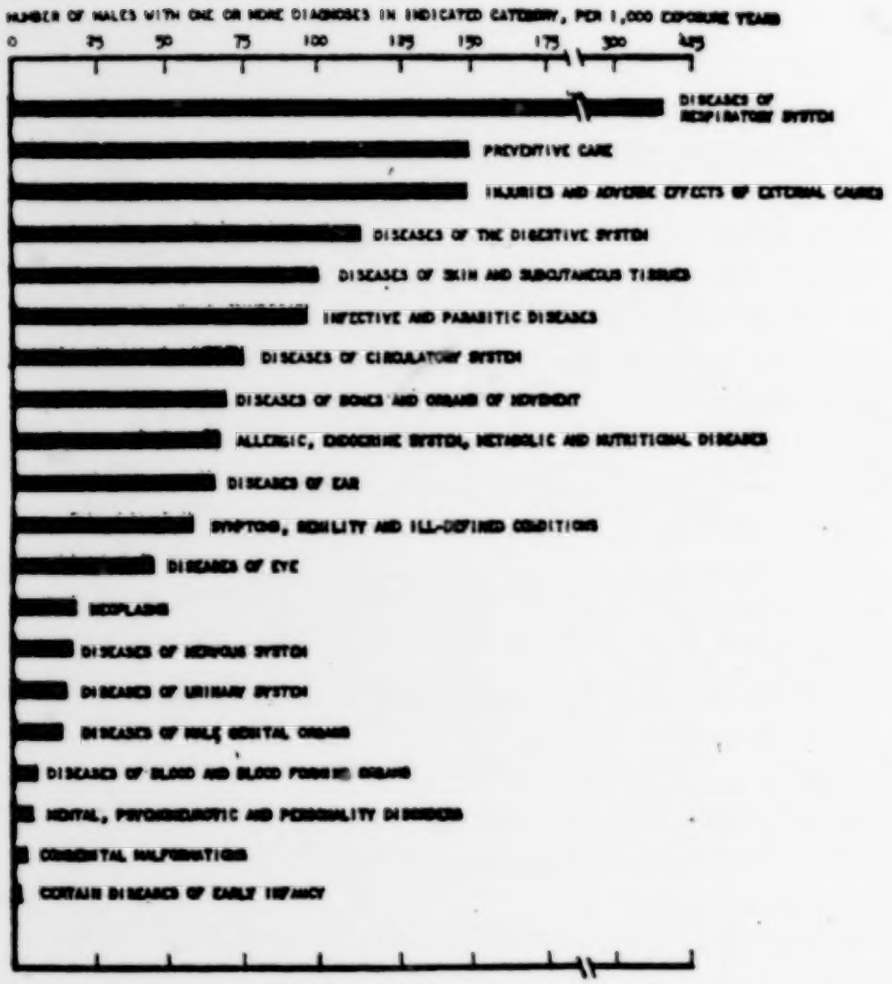
Variations in Incidence Among Males and Females

The comparative longevity of women raises speculation as to the possibly contributory role played by their greater inclination toward medical attention.

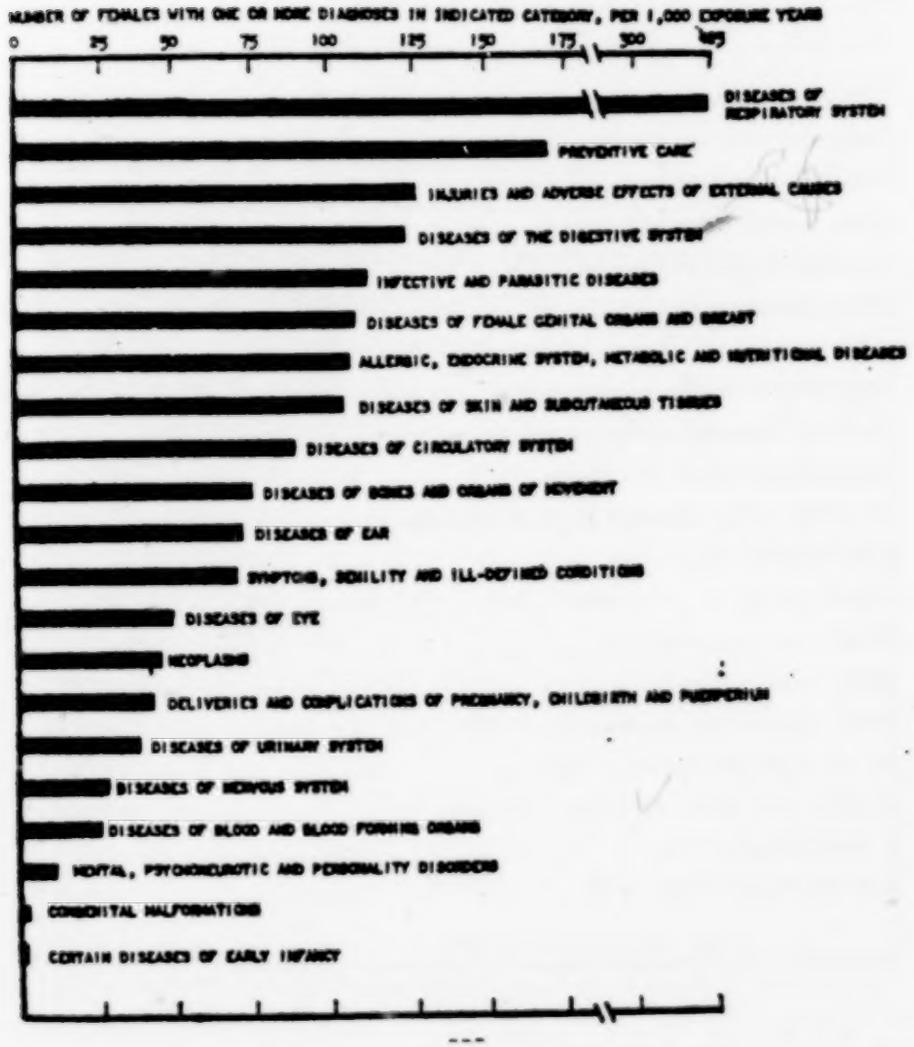
INCIDENCE OF ATTENDED ILLNESS,
BY DIAGNOSTIC CATEGORY
(Comprehensive Plan Sample)



INCIDENCE OF ATTENDED ILLNESS, MALES,
BY DIAGNOSTIC CATEGORY
(Comprehensive Plan Sample)



INCIDENCE OF ATTENDED ILLNESS,
FEMALES, BY DIAGNOSTIC CATEGORY
(Comprehensive Plan Sample)



Age-Sex Trends

Differences in total treated incidence rates between males and females were minor to age 14, with boys' rates slightly higher; substantial at ages 15 to 19, with boys' rates 16 per cent higher; major from ages 20 through 64, with women always much higher; and again minor after 65.

* * *

Adults (Aged 20 or more). One of the most striking findings is the sudden change in incidence rates experienced by each sex at age 20. The change was in opposite directions, boys' rates dropping off and girls' rates rising precipitously. This was found both as to the proportion seeking medical attention and the number of diagnoses reported.

In the case of males, the drop in total reported diagnoses, from 2,070 to 1,385 per thousand, between the late teens and early twenties, was associated with decreases in almost all categories but particularly in injuries, preventive care, and respiratory conditions.

Among females, a good part of the sudden spurt in incidence at age 20 resulted from pregnancies and from disorders of female organs, but there were also substantial increases in the incidence of most other categories—benign neoplasms, infective diseases, disorders of blood, bones, joints, digestive and urinary tract, mental and neurological conditions, circulatory disorders. The highest rate of skin disorders among females was recorded for those aged 20 to 24.

At 20 to 24, total female incidence rates were nearly double the male rates. The gap narrowed with each succeeding age increment, but remained substantial up to age 65.

At no age level did the combined incidence of pregnancy and treatment of female sex organs account for most of the difference in incidence rates between men and women. Up to age 55, women showed higher rates in most categories, the principal exceptions being injuries and skin disorders; but even here, female rates were higher from age 35 on.

Certain disease categories showed a clear upward trend among adults with increasing age, for both sexes—malignant neoplasms, diseases of the nervous system, eye disorders, disorders of bones and joints, circulatory disorders. The latter category showed dramatic changes at every age level after 25; at ages past 65, circulatory diseases topped respiratory diseases as the leading diagnosis and involved well over a quarter of the population, but particularly women. Malignant neoplasms increased dramatically at age 55, doubling the rate found for the previous age interval.

For other disease categories, the age trend was consistently upward among male adults, more erratic among females: benign neoplasms, blood diseases, disorders of the digestive system, urinary tract diseases, allergic-metabolic disorders.

In certain categories the trend was downward—infective diseases, skin disorders, injuries among males, disorders of female sex organs.

The incidence of ear conditions was comparatively steady after age 25.

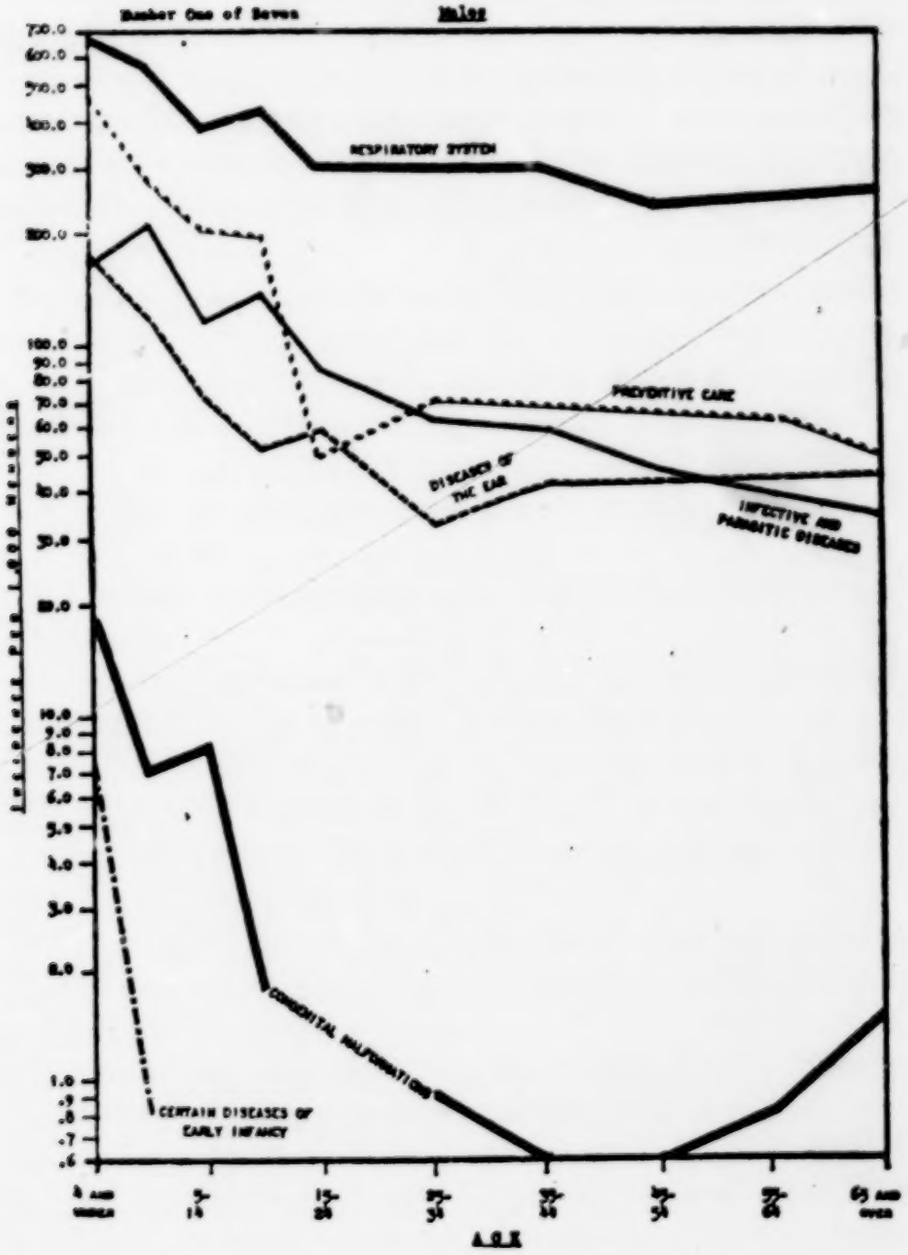
Except for conditions most frequent in childhood—infective, respiratory, minor digestive and ear disorders—males past 65 showed generally highest rates, whereas among females, highest rates were frequently encountered at ages 35 to 44—e.g. benign neoplasms, urinary tract disorders, injuries, allergic-metabolic disorders.

The relative importance of different disease categories to each adult age-sex subgroup changed gradually with increasing age, except for respiratory diseases.

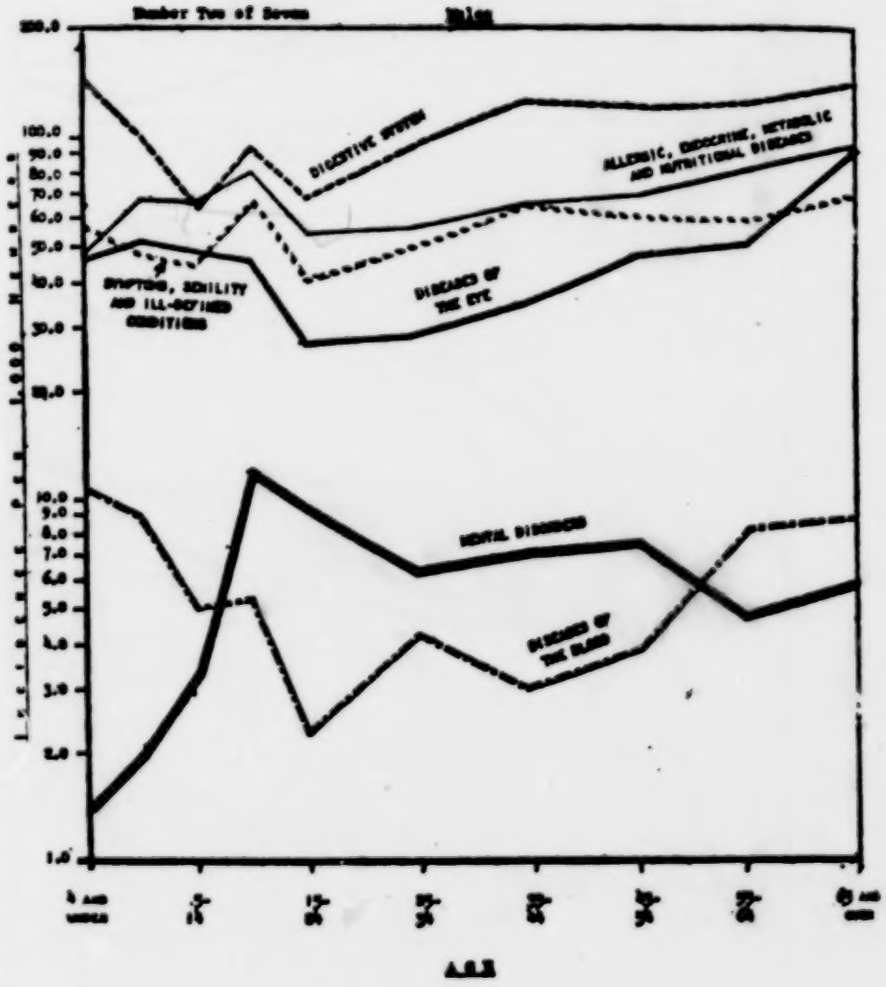
Among males, skin disorders went from second place, at 20–24, to third, at 25–34, to fourth, at 35–44, after which circulatory disorders assumed third place, at ages 45–54, second at 55–64, and first at 65 and over. Digestive diseases went from fifth to fourth to third to second place by ages 45–54. Injuries went from second place, at 25–44, to fourth at ages 45–64 and fifth thereafter. Diseases of bones and joints, outranked by injuries to age 54, surpassed them in frequency after that point.

Female disorders were a leading type of illness among women at every age from 20 through 54. Skin conditions, a leader at ages 20 to 24, were displaced by allergic-metabolic and intestinal disorders, at ages 25 to 44. Allergic-metabolic conditions (including treatment of obesity) were most important at ages 35 to 44. Disorders of bones and joints were fifth in importance among women aged 45 to 54, moved to fourth at the next interval, 55 to 64, and were third at ages 65 on. At the same time, circulatory disorders moved from fourth, to second, to first place.

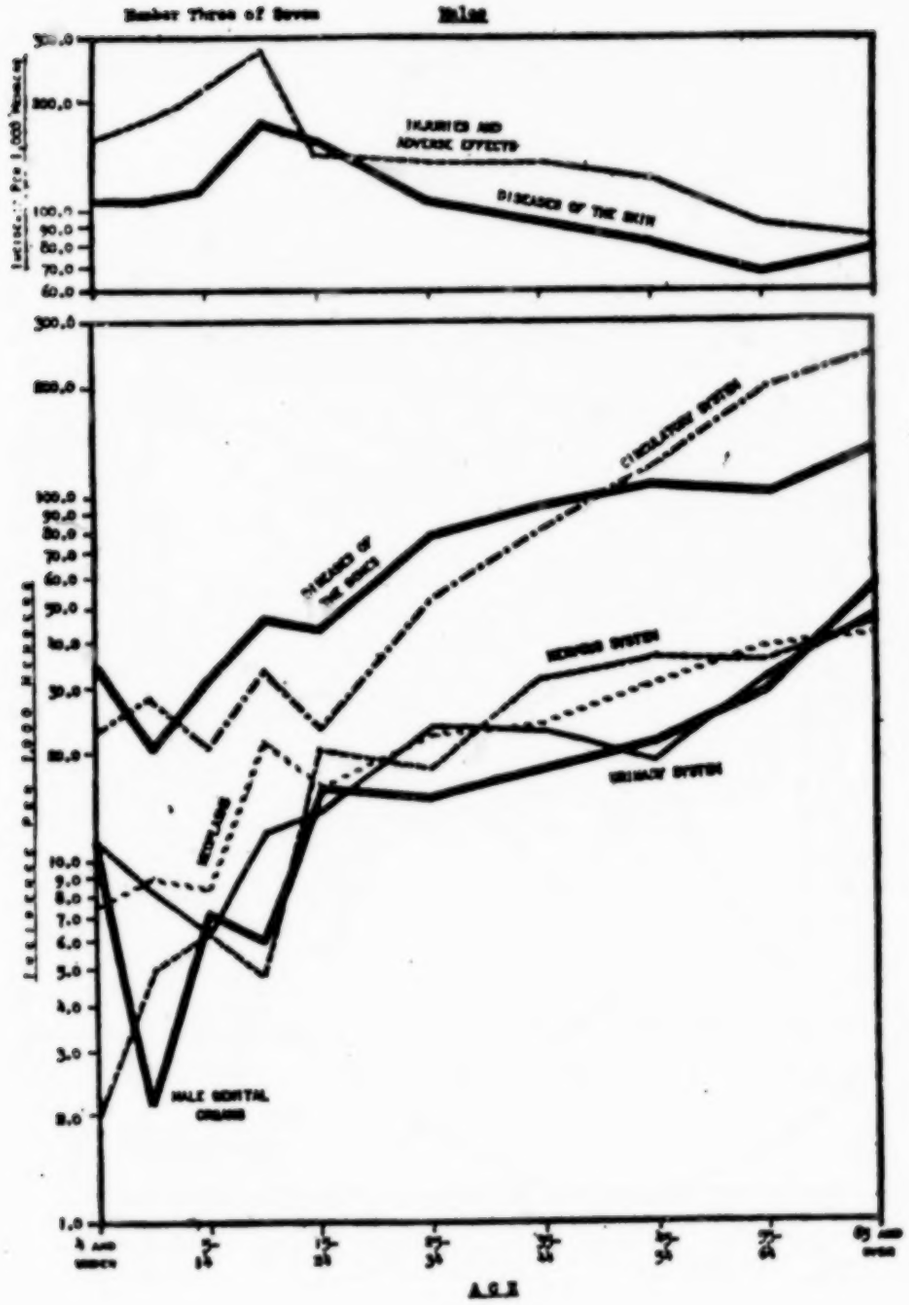
INCIDENCE OF ATTENDED ILLNESS OR PREVENTIVE CARE
BY DIAGNOSTIC CATEGORY, BY AGE AND SEX



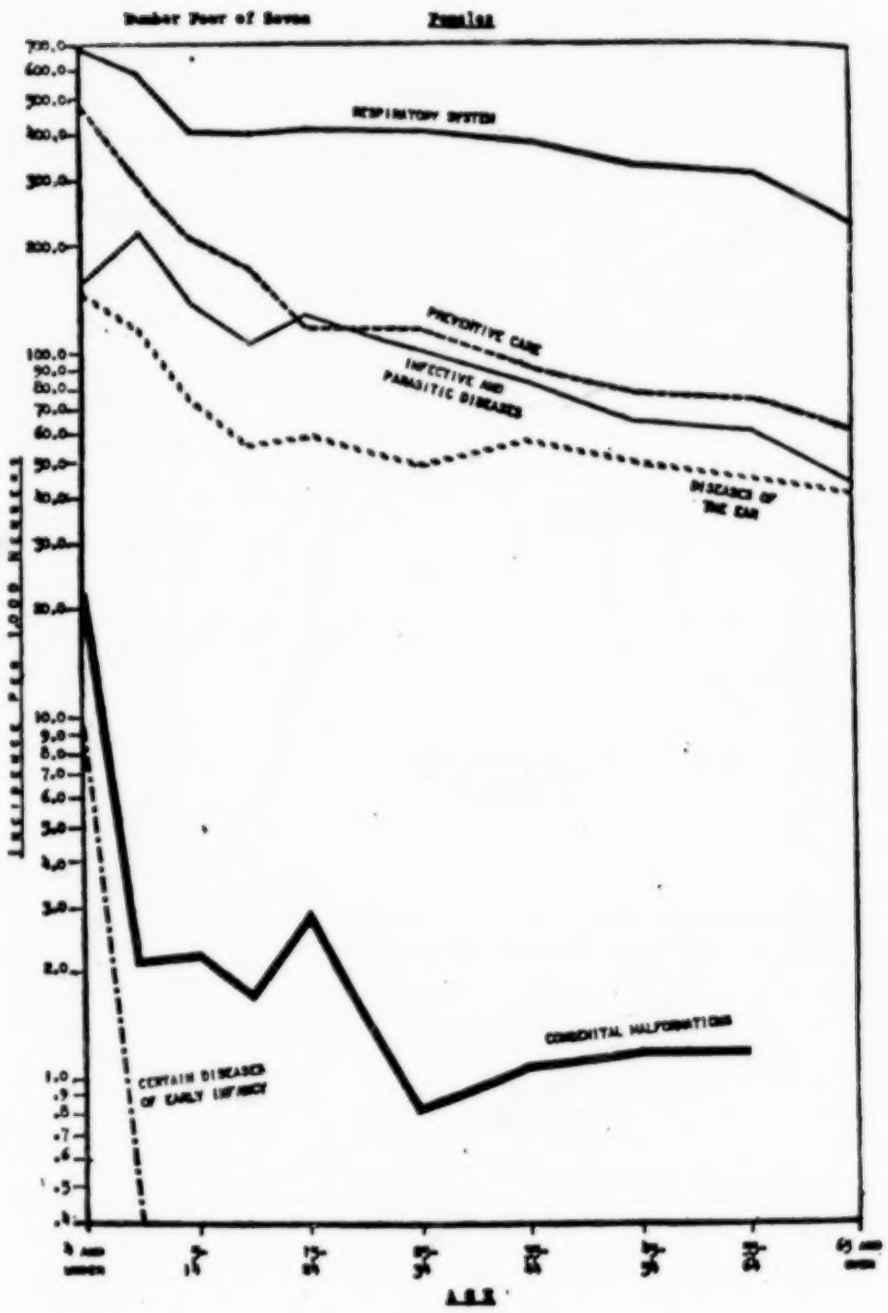
INCIDENCE OF ATTENDED ILLNESS OR PREVENTIVE CARE
BY DIAGNOSTIC CATEGORY, BY AGE AND SEX



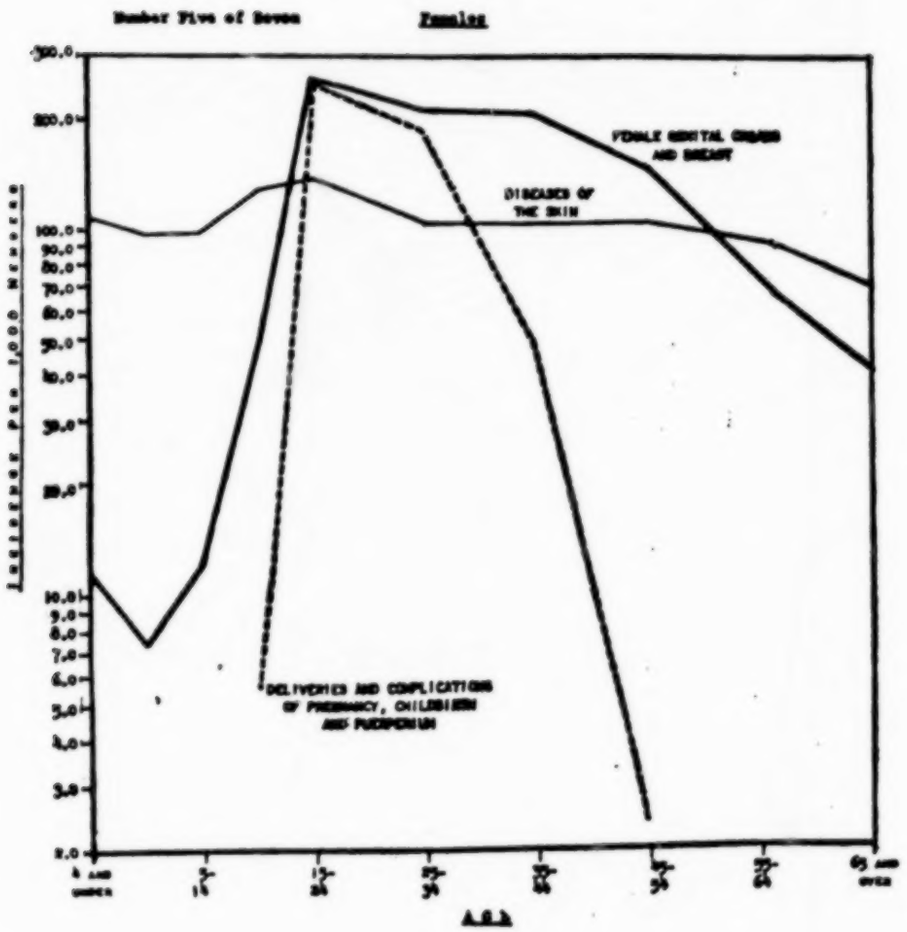
INCIDENCE OF ATTENDED ILLNESS OR PREVENTIVE CARE BY DIAGNOSTIC CATEGORY, BY AGE AND SEX



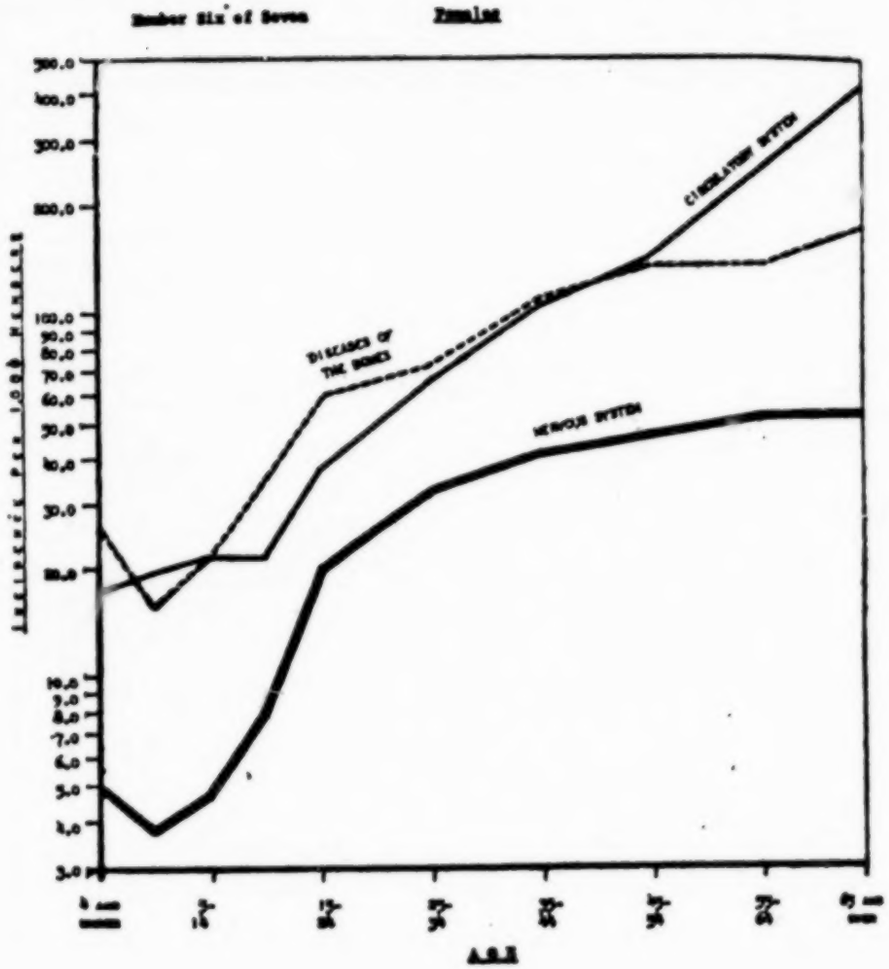
INCIDENCE OF ATTENDED ILLNESS OR PREVENTIVE CARE BY DIAGNOSTIC CATEGORY, BY AGE AND SEX



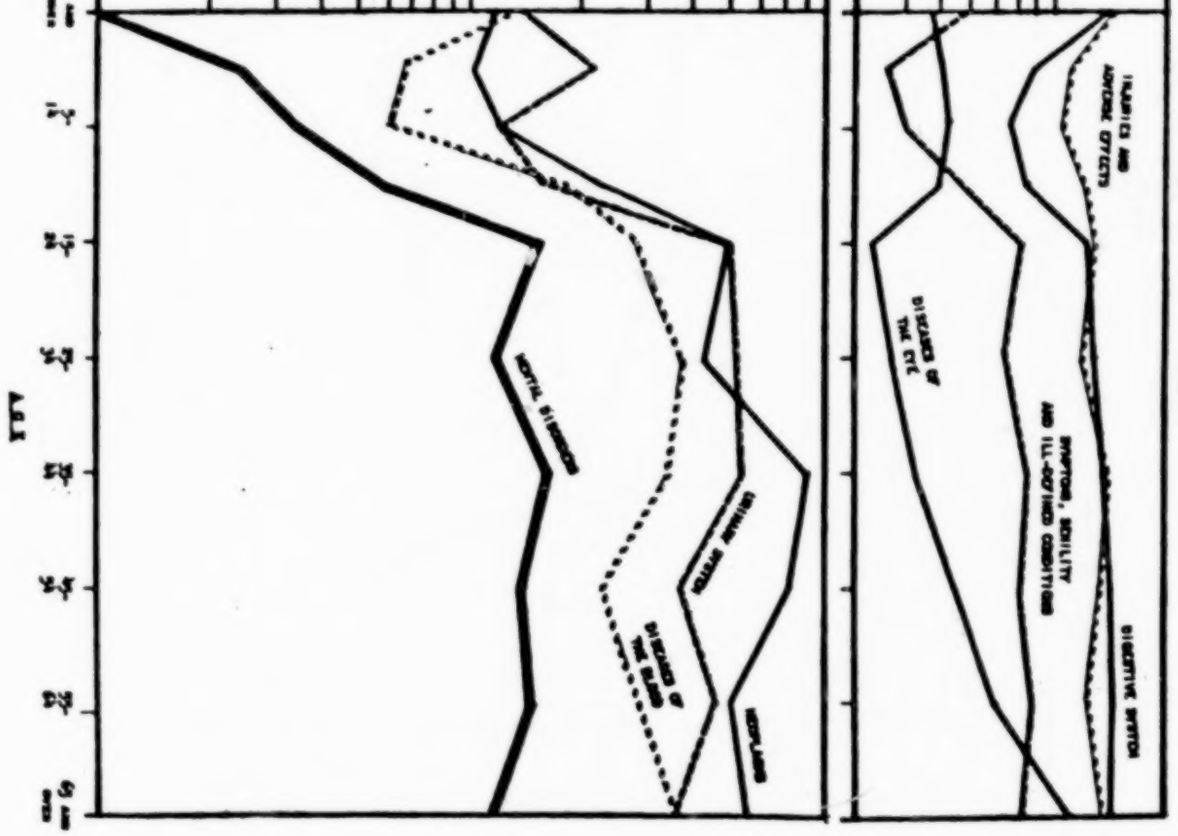
INCIDENCE OF ATTENDED ILLNESS OR PREVENTIVE CARE
BY DIAGNOSTIC CATEGORY, BY AGE AND SEX



INCIDENCE OF ATTENDED ILLNESS OR PREVENTIVE CARE
BY DIAGNOSTIC CATEGORY, BY AGE AND SEX



INCIDENCE OF ATTENDED ILLNESS OR PREVENTIVE CARE
BY DIAGNOSTIC CATEGORY, BY AGE AND SEX



Part II: Ages 20 and Over

DIAGNOSTIC CATEGORY	20–24		25–34		35–44		45–54		55–64		65 AND OVER	
	M	*F*	*M*	*F*	*M*	*F*	*M*	*F*	*M*	*F*	*M*	*F*
TOTAL	% 100.0	% 100.0	% 100.0	% 100.0	% 100.0	% 100.0	% 100.0	% 100.0	% 100.0	% 100.0	% 100.0	% 100.0
Infective and Parasitic Diseases	6.8	5.6	4.9	4.7	4.2	3.7	3.5	3.1	2.7	2.9	2.0	2.2
Neoplasms	1.3	2.2	1.7	1.9	1.7	3.7	2.4	4.0	3.2	3.0	2.6	3.5
Allergic, Endocrine System, Metabolic and Nutritional Diseases	4.5	5.3	4.9	6.9	5.0	7.4	5.2	7.5	5.4	6.1	5.6	5.4
Diseases of Blood and Blood Forming Organs	.1	1.2	.3	1.6	.2	1.4	.3	1.1	.5	1.3	.5	1.5
Mental, Psychoneurotic and Personality Disorders	.7	.7	.5	.5	.5	.7	.5	.7	.3	.7	.5	.7
Diseases of Nervous System	1.6	1.0	1.3	1.5	2.2	1.8	2.5	2.3	2.3	2.5	2.6	2.3
Diseases of the Eye	2.3	1.4	2.4	1.7	2.6	1.9	3.5	2.9	3.5	3.6	5.4	6.0
Diseases of the Ear	4.8	2.8	2.8	2.4	3.2	2.8	3.2	2.6	2.9	2.4	2.6	1.8
Diseases of the Circulatory System	1.8	1.6	4.0	3.2	6.4	5.1	10.1	7.9	16.4	15.2	19.3	26.3
Diseases of the Respiratory System	30.6	22.5	30.2	24.0	27.6	23.1	22.4	20.8	21.7	19.3	19.0	13.1
Diseases of the Digestive System	5.9	6.0	8.1	6.7	9.8	7.4	10.2	8.4	9.8	9.2	9.1	7.6
Diseases of the Urinary System	1.1	2.3	1.7	2.5	1.6	2.6	1.4	1.9	2.1	2.3	2.6	1.7
Diseases of the Male Genital Organs	1.3	—	1.1	—	1.2	—	1.4	—	1.8	—	2.9	—
Diseases of the Female Genital Organs and Breast	—	12.2	—	10.7	—	10.5	—	8.2	—	3.6	—	1.8
Deliveries and Complications of Pregnancy, Childbirth and Puerperium	—	10.6	—	8.2	—	2.1	—	.1	—	0	—	0
Diseases of Skin and Subcutaneous Tissues	14.0	6.8	9.3	5.1	7.1	5.1	6.4	5.6	4.8	4.9	4.8	3.2
Diseases of Bones and Organs of Movement	3.8	2.8	6.1	3.5	7.1	5.6	8.8	7.4	7.5	7.9	7.9	9.1
Injuries and Adverse Effects of External Causes	12.3	6.0	11.4	5.9	10.2	6.8	8.9	7.6	6.7	7.1	5.5	6.9
Other †	3.2	3.8	4.0	3.7	4.7	4.3	4.8	4.3	4.2	4.5	4.1	4.1
Preventive Care	3.9	5.2	5.3	5.3	4.7	4.0	4.5	3.6	4.2	3.5	2.8	2.8

* Adjusted to age-sex composition of general population of area.

† Other includes: Symptoms, Senility and Ill-Defined Conditions; Congenital Malformations; and Certain Diseases of Early Infancy.

TABLE 131. *(Cont'd)* Summary: Incidence of Attended Illness or Preventive Care, by Diagnostic Category, by Age and Sex (and Adjusted to Age-Sex Composition of General Population)

Part II: Ages 20 and Over

DIAGNOSTIC CATEGORY		GROSS AND NET INCIDENCE PER 1000 EXPOSURE YEARS											
		20–24		25–44		35–44		45–54		55–64		65 AND OVER	
		M	F	M	F	M	F	M	F	M	F	M	F
Total–Including Undetermined	Gross*	1384.8	2613.8	1427.7	2475.0	1582.8	2504.3	1563.5	2300.2	1696.0	2292.2	2022.2	2415.7
	Net†	668.2	972.6	672.1	896.2	673.2	865.4	650.0	802.4	664.5	806.9	745.6	898.3
Infective and Parasitic Diseases	Gross	87.6	134.0	68.5	108.5	62.2	84.8	51.2	66.1	42.2	61.8	37.0	49.4
	Net	85.3	126.8	63.9	99.2	60.5	82.6	47.5	64.1	39.0	61.2	35.5	43.6
Neoplasms	Gross	16.1	53.3	22.9	43.0	24.5	85.7	34.8	84.5	51.0	64.1	48.8	78.5
	Net	16.1	50.4	22.0	42.6	23.1	78.1	30.0	72.1	37.5	49.7	41.4	55.2
Malignant Neoplasms	Gross	0	4.3	.9	3.5	3.1	7.9	9.3	13.8	22.7	23.1	23.6	29.1
	Net	0	4.3	.9	3.5	2.8	7.4	7.6	12.4	18.3	17.9	20.7	23.3
Allergic, Endocrine System, Metabolic and Nutritional Diseases	Gross	47.6	126.8	65.7	158.8	73.3	170.0	76.0	159.4	85.7	129.3	103.5	122.1
	Net	35.3	112.3	57.5	137.9	66.1	150.5	69.6	139.3	80.5	117.8	94.7	116.3
Diseases of Blood and Blood Forming Organs	Gross	2.3	28.8	4.3	37.2	3.1	33.4	3.9	22.4	8.4	28.3	8.9	34.9
	Net	2.3	28.8	4.3	37.2	3.1	33.4	3.9	22.4	8.4	28.3	8.9	34.6
Mental Psychoneurotic and Personality Disorders	Gross	9.2	15.8	6.9	12.0	7.3	17.0	7.6	14.9	4.8	14.4	5.9	14.5
	Net	9.2	15.8	6.5	12.0	7.3	16.4	7.6	13.8	4.8	14.4	5.9	11.6
Diseases of Nervous System	Gross	20.7	23.1	18.2	33.3	32.1	42.4	36.2	48.0	35.5	52.5	47.3	52.3
	Net	20.7	20.2	17.7	32.9	31.5	40.2	35.3	46.8	34.7	50.8	44.4	52.3
Diseases of the Eye	Gross	30.0	34.6	31.4	38.0	37.6	43.3	51.2	62.3	55.0	76.2	90.1	136.6
	Net	27.6	33.1	28.9	37.2	35.7	42.7	47.8	55.7	50.2	70.4	91.7	110.5

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Diseases of the Ear	Gross	62.2	67.7	37.2	53.9	46.8	64.8	46.4	56.3	45.0	51.4	48.8	40.7
	Net	59.9	59.1	33.7	48.6	42.7	56.6	43.0	49.1	42.6	44.5	45.9	40.7
Diseases of the Circulatory System	Gross	23.1	38.9	54.0	72.8	94.0	118.2	143.9	168.9	258.6	323.9	356.5	595.9
	Net	23.1	38.9	51.4	67.4	80.0	105.5	117.0	140.8	192.4	245.4	248.5	418.6
Diseases of the Respiratory System	Gross	394.0	541.8	406.2	549.8	408.2	532.8	324.3	444.1	341.0	409.3	350.8	296.5
	Net	308.8	407.8	308.9	400.6	308.1	378.1	248.5	326.1	257.0	312.9	287.8	229.7
Diseases of the Digestive System	Gross	76.0	144.1	109.7	154.2	144.5	170.0	147.9	178.4	153.8	194.6	167.2	171.5
	Net	69.1	126.8	95.9	127.5	124.7	138.0	121.9	142.8	124.3	147.2	140.5	145.3
Diseases of the Urinary System	Gross	13.8	54.8	23.3	56.6	24.0	58.8	19.8	40.5	34.2	49.7	51.8	37.8
	Net	13.8	49.0	22.5	51.1	22.3	53.5	18.9	36.2	30.7	45.6	45.9	34.9
Diseases of the Male Genital Organs	Gross	16.1	—	14.7	—	17.8	—	20.9	—	29.1	—	54.7	—
	Net	16.1	—	14.7	—	17.8	—	20.9	—	29.1	—	54.7	—
Diseases of the Female Genital Organs and Breast	Gross	—	295.3	—	245.7	—	242.7	—	173.8	—	76.8	—	40.7
	Net	—	253.6	—	211.2	—	206.2	—	147.1	—	70.4	—	40.7
Deliveries and Complications of Pregnancy, Childbirth and Puerperium	Gross	—	256.5	—	186.7	—	47.5	—	2.3	—	0	—	0
	Net	—	250.7	—	182.9	—	47.5	—	2.3	—	0	—	0
Diseases of Skin and Subcutaneous Tissues	Gross	179.7	164.3	125.3	117.8	104.3	117.9	92.4	118.6	75.7	105.1	88.7	72.7
	Net	156.7	138.3	108.4	102.3	93.4	101.8	80.6	103.7	67.7	92.4	76.9	69.8
Diseases of Bones and Organs of Movement	Gross	48.4	67.7	82.1	80.6	104.6	128.4	127.8	156.9	117.5	168.0	145.0	206.4
	Net	43.8	59.1	77.8	71.7	92.3	110.0	108.8	133.9	101.2	136.3	133.1	171.5
Injuries and Adverse Effects of External Causes	Gross	159.0	144.1	154.2	134.4	150.9	156.4	129.5	160.9	104.8	150.1	102.1	157.0
	Net	140.6	129.7	135.6	119.7	135.2	139.1	121.6	134.2	92.0	125.3	85.8	133.7
Symptoms, Senility and Ill-Defined Conditions	Gross	41.5	89.3	53.1	84.1	69.4	96.4	67.6	91.6	64.9	94.7	74.0	93.0
	Net	41.5	83.6	50.5	74.4	65.0	86.8	60.5	81.9	59.0	89.5	69.5	84.3
Preventive Care	Gross	50.7	125.4	70.8	120.5	69.4	93.0	65.6	77.3	65.3	75.1	51.8	64.0
	Net	50.7	118.2	70.8	118.6	68.3	91.3	64.5	76.7	63.3	73.9	50.3	61.0
Other (Congenital Malformations and Certain Diseases of Early Infancy)	Gross	0	2.9	.9	.8	.6	1.1	.6	1.2	.8	1.2	1.5	0
	Net	0	2.9	.9	.8	.6	1.1	.6	1.2	.8	1.2	1.5	0

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* Gross rate is based on sum of patients reported for each component of a category; this represents duplicate count of persons treated for more than one condition in that category.

† Net rate is based on number of patients with any condition listed for a specified category.

‡ Adjusted to age-sex composition of general population of area.

TABLE 132. *(Cont'd)* Incidence of Attended Illness or Preventive Care, by Diagnosis, by Age and Sex (and Adjusted to Age-Sex Composition of General Population)

Part II: Ages 20 and Over

DIAGNOSIS		NUMBER OF MEMBERS WITH INDICATED DIAGNOSIS PER 1,000 EXPOSURE YEARS											
		20–24		25–34		35–44		45–54		55–64		65 AND OVER	
		M	*F*	*M*	*F*	*M*	*F*	*M*	*F*	*M*	*F*	*M*	*F*
TOTAL	Gross	1384.8	2813.8	1427.7	2475.0	1582.8	2504.3	1563.5	2300.2	1696.0	2292.2	2022.2	2415.7
	Net	668.2	972.6	672.1	896.2	673.2	865.4	650.0	802.4	664.5	808.9	745.6	898.3
I													
Infective and Parasitic Diseases	Gross	87.6	134.0	66.5	106.5	82.2	84.8	51.2	66.1	42.2	61.6	37.0	49.4
	Net	85.3	126.8	63.9	99.2	80.5	82.6	47.5	64.1	39.0	61.2	35.5	43.6
Streptococcal Sore Throat		13.8	18.7	13.4	22.9	11.1	16.1	9.9	12.1	7.5	5.8	3.0	2.9
Measles		0	4.3	1.3	2.7	0	.6	0	0	0	0	0	0
Rubella (German Measles)		9.2	27.4	2.2	16.6	2.0	5.9	.8	1.4	0	.8	0	0
Chicken Pox		0	0	0	.4	.3	.3	0	0	0	0	0	0
Mumps		0	0	0	1.2	1.4	1.1	.9	.3	1.2	.8	0	0
Infectious Hepatitis		0	0	0	.4	.3	0	.8	0	0	.8	0	0
Glandular Fever (Infectious Mononucleosis)		4.6	4.3	.4	2.7	.8	.9	0	0	0	1.2	0	0
Intestinal Virus		34.8	60.5	35.0	46.9	37.9	49.2	29.4	41.4	24.7	41.5	19.2	23.3
Dermatophytoses		16.2	5.8	7.3	4.6	5.3	5.9	5.1	5.5	3.6	4.0	1.5	8.7
Other		9.2	13.0	6.9	8.1	3.3	4.8	4.5	5.4	5.2	7.5	13.3	14.5

TABLE 132. *(Cont'd)* Incidence of Attended Illness or Preventive Care, by Diagnosis, by Age and Sex (and Adjusted to Age-Sex Composition of General Population)

Part II: Ages 20 and Over (Cont'd)

DIAGNOSIS		NUMBER OF MEMBERS WITH INDICATED DIAGNOSIS PER 1,000 EXPOSURE YEARS											
		20–24		25–34		35–44		*M*	*F*	*M*	*F*	*M*	*F*
		M	*F*	*M*	*F*	*M*	*F*	45–54		55–64		65 AND OVER	
II	Gross	16.1	53.3	22.9	43.0	24.5	85.7	34.8	84.5	51.0	64.1	48.8	78
Neoplasms	Net	16.1	50.4	22.0	42.6	23.1	78.1	30.0	72.1	37.5	49.7	41.4	58
	Gross	0	4.3	.9	3.5	3.1	7.9	9.3	13.8	22.7	23.1	23.6	28
Malignant Neoplasms	Net	0	4.3	.9	3.5	2.8	7.4	7.6	12.4	18.3	17.9	20.7	24
Digestive System—Including Mouth		0	0	0	0	.3	.3	2.3	.9	4.4	3.5	8.9	5
Respiratory System		0	0	.4	0	0	.8	1.4	.6	4.8	1.2	5.9	3
Breast		—	1.5	—	1.5	—	2.6	—	5.2	—	5.8	—	1
Female Genital Organs		—	1.4	—	.4	—	2.3	—	1.4	—	3.5	—	0
Male Genital Organs		0	—	0	—	.3	—	.6	—	2.4	—	2.9	
Urinary System		0	0	0	.8	.3	0	.6	0	2.4	0	0	0
Skin		0	0	.5	0	.8	0	1.4	1.4	3.2	1.7	2.9	2
Eye		0	0	0	0	0	0	0	.3	0	.8	0	0
Nervous System—Including Brain		0	0	0	0	0	.3	.6	.3	1.6	0	0	0
Endocrine Glands		0	1.4	0	0	0	.3	.3	.6	0	.8	0	0
Bone		0	0	0	0	0	0	0	.8	.4	0	0	0
Connective Tissue		0	0	0	0	0	0	0	0	0	0	0	0
Lymphosarcoma		0	0	0	0	0	.8	.3	0	0	.8	0	0
Hodgkin's Disease		0	0	0	0	.3	0	0	0	0	.8	0	0
Other Lymphoma		0	0	0	0	.3	0	.2	0	0	.5	0	0
Multiple Myeloma		0	0	0	0	0	0	0	0	0	.5	0	0
Leukemia		0	0	0	0	0	.3	.2	1.4	.8	0	0	0
Not Elsewhere Classified		0	0	0	.8	.8	.8	1.4	1.1	2.7	4.0	3.0	2

Neoplasms (Cont'd)

	Gross	16.1	47.6	22.0	38.0	20.3	74.1	24.6	66.1	24.3	35.8	23.7	43.6
Benign Neoplasms	Net	16.1	47.6	21.6	37.8	20.1	70.4	23.5	60.6	23.9	32.3	23.7	37.8
Mouth		0	1.4	.4	.8	.3	2.0	1.2	1.2	1.2	1.7	0	5.8
Rectum		0	0	.4	.4	.3	.8	1.4	1.2	2.4	2.9	5.9	0
Breast		—	8.7	—	2.7	—	7.1	—	6.0	—	1.7	—	2.9
Female Genital Organs		—	15.9	—	19.4	—	39.3	—	27.9	—	5.6	—	5.8
Skin		11.5	13.0	17.3	12.0	12.5	17.0	12.7	16.9	9.6	13.9	7.4	17.5
Other		4.6	6.6	3.9	2.7	7.2	7.9	9.3	12.9	11.1	9.8	10.4	11.6
	Gross	0	1.4	0	1.5	1.1	3.7	.9	4.6	4.0	5.2	1.5	5.8
Unspecified Neoplasms	Net	0	1.4	0	1.5	1.1	3.7	.9	4.6	4.0	5.2	1.5	5.8
Rectum		0	0	0	0	0	.3	0	.6	0	.8	0	0
Breast		—	0	—	0	—	1.7	—	.9	—	1.7	—	0
Female Genital Organs		—	1.4	—	1.1	—	.3	—	.3	—	0	—	0
Other		0	0	0	.4	1.1	1.4	.9	2.8	4.0	2.9	1.4	5.8
III													
Allergic, Endocrine System, Metabolic and Nutritional Diseases	Gross	57.6	126.8	65.7	158.8	73.3	170.0	76.0	159.4	65.7	129.3	103.5	122.1
	Net	55.3	112.3	57.5	137.9	66.1	150.5	69.6	139.3	60.5	117.8	94.7	116.3
Hay Fever		16.1	18.7	16.9	23.6	15.9	18.1	9.9	19.8	8.0	14.4	13.3	5.8
Asthma		6.9	8.7	10.8	12.4	8.4	13.6	8.8	16.9	13.5	13.9	14.8	14.6
Other Allergic Diseases		18.5	17.3	12.1	15.9	9.8	15.6	7.6	15.5	6.0	8.7	11.8	5.8
Diseases of Thyroid Gland		0	23.1	5.2	26.3	3.6	32.5	4.2	29.9	4.0	15.0	3.0	20.3
Diabetes Mellitus		4.6	1.4	1.7	5.4	8.6	7.6	16.1	12.9	36.2	30.0	47.3	43.6
Obesity (Not Otherwise Specified)		11.5	53.3	13.8	64.7	20.6	71.8	16.7	52.0	10.0	39.8	4.4	26.2
Other		0	4.3	5.2	10.5	6.4	10.8	12.7	12.4	8.0	7.5	8.9	5.8
IV													
Diseases of Blood and Blood Forming Organs	Gross	2.3	28.8	4.3	37.2	3.1	33.4	3.9	22.4	8.4	28.3	8.9	34.9
	Net	2.3	28.8	4.3	37.2	3.1	33.4	3.9	22.4	8.4	28.3	8.9	34.9
Anemias		2.3	28.8	3.4	36.0	2.0	31.1	3.1	21.5	6.8	24.3	3.0	32.0
Other		0	0	.9	1.2	1.1	2.3	.8	.9	1.6	4.0	5.9	2.9

TABLE 132. *(Cont'd)* Incidence of Attended Illness or Preventive Care, by Diagnosis, by Age and Sex (and Adjusted to Age-Sex Composition of General Population)

Part II: Ages 20 and Over (Cont'd)

		NUMBER OF MEMBERS WITH INDICATED DIAGNOSIS PER 1,000 EXPOSURE YEARS											
		20–24		25–34		35–44		45–54		55–64		65 AND OVER	
DIAGNOSIS		*M*	*F*	*M*	*F*	*M*	*F*	*M*	*F*	*M*	*F*	*M*	*F*
V													
Mental, Psychoneurotic and Personality Disorders	Gross	9.2	15.8	6.9	12.0	7.3	17.0	7.6	14.9	4.8	14.4	8.9	14.5
	Net	9.2	15.8	6.5	12.0	7.3	16.4	7.6	13.8	4.8	14.4	5.9	11.6
Chronic Brain Disorders		0	0	0	0	.3	0	.3	.3	.4	0	3.0	0
Psychoses		0	2.9	2.2	1.1	.8	2.3	0	1.7	0	1.7	3.0	2.9
Psychophysiologic, Autonomic and Visceral Disorders		0	0	0	.4	.3	.8	.3	.3	0	.6	0	0
Psychoneuroses		9.2	10.1	4.3	8.5	5.8	13.3	6.8	10.6	4.4	11.5	2.9	8.7
Personality Disorders		0	2.8	.4	1.2	.3	.2	.2	2.0	0	.6	0	2.9
Mental Deficiency		0	0	0	.8	0	.3	0	0	0	0	0	0
VI	Gross	20.7	23.1	18.2	33.3	32.1	42.4	36.2	48.0	35.5	52.5	47.3	52.3
Diseases of Nervous System	Net	20.7	20.2	17.7	32.9	31.5	40.2	35.3	46.8	34.7	50.8	44.4	52.3
Stroke		0	0	0	0	.3	0	0	0	0	0	2.9	0
Multiple Sclerosis		0	0	0	.4	.3	1.7	0	.6	.4	1.1	0	0
Migraine		6.9	2.9	1.3	10.1	5.6	8.7	1.4	6.9	1.6	5.8	0	0
Epilepsy		0	0	.4	.4	.5	.6	.6	.3	0	1.2	1.5	0
Sciatica		2.3	4.3	3.5	4.2	5.0	5.4	8.2	9.8	7.6	9.8	5.9	8.7
Other		11.5	15.9	13.0	18.2	20.4	26.0	26.0	30.4	25.9	34.6	37.0	43.6

VII	Gross	30.0	34.6	32.4	38.0	37.6	43.3	51.2	62.3	55.0	76.2	99.1	136.6
Diseases of Eye	Net	27.6	33.1	28.9	37.2	35.7	42.7	47.8	55.7	50.2	70.4	91.7	110.5
Conjunctivitis and Ophthalmia		18.5	20.2	17.7	17.5	17.3	19.3	16.7	24.1	16.7	23.1	25.1	29.1
Strabismus		2.3	5.8	.9	2.3	1.1	1.4	1.7	2.0	.4	.6	0	2.9
Cataract		0	0	.4	.4	0	1.4	2.5	2.3	5.6	8.1	22.2	23.2
Glaucoma		0	0	0	0	1.1	2.0	4.0	3.2	6.8	6.9	13.3	32.0
Detachment of Retina		0	0	0	.4	0	0	0	0	.4	1.1	0	2.9
Other		9.2	8.6	13.4	17.4	18.1	19.2	24.3	30.7	25.1	36.4	38.5	46.5
VIII	Gross	62.2	67.7	37.2	53.9	46.8	64.8	46.4	56.3	45.0	51.4	48.8	40.7
Diseases of Ear	Net	59.9	59.1	33.7	48.8	42.7	56.6	43.0	49.1	42.6	44.5	45.9	40.7
Otitis Externa		11.5	11.5	6.5	7.8	8.4	11.1	6.2	9.2	4.0	6.9	5.9	8.7
Otitis Media		34.6	44.7	16.9	33.3	18.1	32.0	14.7	24.4	15.1	19.1	17.8	8.7
Deafness		2.3	1.4	0	.4	.8	.6	0	.9	2.4	5.2	4.4	0
Other		13.8	10.1	13.8	12.4	19.5	21.1	25.5	21.8	23.5	20.2	20.7	23.3
IX	Gross	23.1	38.9	54.0	72.8	94.0	118.2	145.9	168.9	258.6	323.9	356.5	595.9
Diseases of Circulatory System	Net	23.1	38.9	51.4	67.4	80.0	105.5	117.0	140.8	192.4	245.4	248.5	418.6
Rheumatic Fever without Mention of Heart		0	0	0	.4	.3	.3	.8	.3	.4	0	0	0
	Gross	2.3	5.8	11.7	13.1	35.1	21.5	65.9	44.5	129.1	132.8	221.9	250.0
Diseases of Heart	Net	2.3	5.8	9.9	11.2	27.6	20.1	47.5	36.2	94.0	101.6	139.8	194.8
Rheumatic Heart Disease		0	0	.9	6.8	2.5	3.1	2.8	4.3	4.0	9.8	1.5	5.8
Arteriosclerotic Heart Disease		0	0	1.3	.4	4.2	2.0	10.5	6.9	34.7	25.4	81.4	69.8
Acute Coronary Occlusion		0	0	.9	.8	3.9	.3	11.3	.9	13.9	8.1	16.3	20.3
Coronary Insufficiency		0	0	3.5	1.5	7.8	8.4	13.6	7.2	24.7	20.2	34.0	46.5
Angina Pectoris		0	1.5	1.7	1.1	7.0	4.2	12.7	7.7	16.7	15.6	25.1	28.2
Hypertensive Heart Disease		0	0	0	1.2	1.9	2.3	4.0	6.6	9.6	28.9	34.0	49.4
Other		2.3	4.3	3.4	1.5	7.8	6.2	11.0	10.9	25.5	24.2	29.6	32.0

TABLE 132. *(Cont'd)* Incidence of Attended Illness or Preventive Care, by Diagnosis, by Age and Sex (and Adjusted to Age-Sex Composition of General Population)

Part II: Ages 20 and Over (Cont'd)

		NUMBER OF MEMBERS WITH INDICATED DIAGNOSIS PER 1,000 EXPOSURE YEARS											
		20–24		25–34		35–44		45–54		55–64		65 AND OVER	
DIAGNOSIS		M	F	M	F	M	F	M	F	M	F	M	F
Diseases of Veins and Arteries	Gross	20.8	33.1	42.3	59.3	58.6	96.4	79.4	124.1	129.1	191.1	134.6	345
Other than Heart	Net	20.8	33.1	42.3	56.6	55.5	89.4	76.1	124.1	123.5	179.0	127.2	309
Hypertensive Diseases		4.6	1.4	13.4	18.6	22.9	35.3	41.0	75.8	82.4	131.1	87.3	255
Hypotension		0	8.6	2.6	6.2	3.6	7.6	2.3	4.3	2.4	4.0	1.5	5
Hemorrhoids		13.9	8.7	19.4	13.6	19.8	22.1	21.5	17.0	12.4	16.2	5.9	20
General Arteriosclerosis		0	0	0	0	0	.3	.3	1.1	6.0	5.8	7.4	20
Varicose Veins of Lower Extremities		0	2.9	.9	6.2	2.5	6.8	2.2	6.3	2.8	6.3	4.4	6
Pulmonary Embolism and Infarction		0	0	0	.4	0	.8	1.1	0	.4	1.2	0	0
Lymphadenitis		2.3	10.1	2.6	5.4	3.6	6.8	2.2	5.2	2.8	2.3	0	0
Other		0	1.4	3.4	8.9	6.2	16.7	8.8	14.4	19.9	24.2	28.1	34
X	Gross	394.0	541.8	408.2	549.8	408.2	532.8	324.3	444.1	341.0	409.3	350.6	296
Diseases of Respiratory System	Net	308.8	407.8	308.9	400.6	308.1	378.1	248.5	326.1	257.0	312.9	267.8	229
Acute Nasopharyngitis		20.7	31.7	23.8	32.9	24.8	31.7	19.2	27.3	20.7	27.1	14.8	5
Pharyngitis		58.9	96.5	67.8	92.6	60.2	78.6	44.1	58.3	29.5	42.7	41.4	32
Tonsillitis		39.2	36.0	31.5	32.9	18.1	22.6	11.3	8.6	5.6	7.5	7.4	2
Hypertrophy of Tonsils		9.2	1.4	.9	2.7	1.1	2.6	.3	1.2	1.2	1.2	1.5	0
Laryngitis and Tracheitis		2.3	17.3	12.5	18.2	14.2	21.5	9.9	19.0	7.6	18.5	11.8	14
Sinusitis		18.4	33.2	25.1	40.7	29.6	34.2	22.1	35.0	19.5	24.8	11.8	8
Influenza		20.8	37.5	31.5	40.3	34.0	41.6	29.7	32.8	27.1	32.9	20.7	23
Pneumonia		6.9	7.2	8.6	10.9	7.8	13.3	7.4	14.9	17.9	18.5	10.4	17
Bronchitis		69.1	87.9	61.8	89.9	71.4	96.7	66.4	95.9	80.5	86.0	99.1	52
Other Diseases of Respiratory Tract		142.9	183.0	139.1	180.9	140.0	180.7	108.3	144.8	112.3	140.3	109.5	127.
Diseases of Lungs		4.6	10.1	5.6	7.8	7.0	9.3	7.6	8.3	19.1	9.8	22.2	11

XI													
Diseases of the Digestive System	Gross	76.0	144.1	109.7	154.2	144.5	170.0	147.9	178.4	153.8	194.6	167.2	171.5
	Net	69.1	126.8	95.9	127.5	124.7	138.0	121.9	142.8	124.3	147.2	140.5	145.3
Stomatitis		2.3	0	1.7	3.5	1.7	3.1	2.0	3.2	0	1.7	0	0
Other Diseases of the Buccal Cavity and Esophagus		6.9	7.2	3.9	4.3	5.3	5.4	3.7	6.0	2.4	8.7	1.5	2.9
Ulcers		9.2	7.2	9.9	10.1	18.4	13.9	24.6	14.9	20.7	12.7	31.0	8.7
Gastritis and Duodenitis		13.8	20.2	26.3	31.8	26.5	30.3	28.3	29.6	20.7	32.9	26.6	23.3
Other Diseases of Stomach and Duodenum		4.6	2.9	3.4	5.0	5.9	5.6	6.2	6.3	6.8	13.3	10.4	2.9
Appendicitis		0	2.9	.9	2.7	1.1	1.4	2.0	.9	1.2	1.7	0	0
Hernia of Abdominal Cavity		0	0	3.5	2.3	6.1	4.8	9.9	8.9	14.8	12.7	20.7	17.4
Gastroenteritis and Colitis (Except Ulcerative)		27.7	69.1	36.3	61.2	47.4	60.8	34.2	57.2	45.8	52.5	31.1	61.0
Other Diseases of Intestines and Peritoneum		9.2	21.6	19.0	14.3	21.8	24.9	23.7	26.1	25.5	24.3	31.1	26.2
Diseases of Liver, Gall Bladder and Pancreas	Gross	2.3	13.0	4.8	19.0	10.3	19.8	13.3	25.3	15.9	34.1	14.8	29.1
	Net	2.3	13.0	4.8	19.0	9.8	19.5	12.2	24.4	15.5	32.9	13.3	29.1
Diseases of Liver		0	1.5	.5	1.9	3.3	2.3	5.4	1.7	4.4	1.7	4.4	0
Diseases of Gall Bladder		2.3	11.5	3.0	16.7	5.9	16.4	5.9	22.1	11.1	29.5	8.9	26.2
Diseases of Pancreas		0	0	1.3	.4	1.1	1.1	2.0	1.5	.4	2.9	1.5	2.9
XII													
Diseases of Urinary System	Gross	13.8	54.8	23.3	56.6	24.0	58.8	19.8	40.5	34.2	49.7	51.8	37.8
	Net	13.8	49.0	22.5	51.1	22.3	53.5	18.9	36.2	30.7	45.6	45.9	34.9
Nephritis and Nephrosis		0	0	.9	1.2	.3	1.7	.6	.8	.4	2.3	0	0
Cystitis		2.3	40.4	8.2	35.6	9.2	33.6	6.2	25.9	15.9	33.5	16.3	26.2
Other		11.5	14.4	14.2	19.8	14.5	23.5	13.0	13.8	17.9	13.9	35.5	11.6
XIII													
Diseases of Male Genital Organs (Excluding Neoplasms)	Gross	16.1	—	14.7	—	17.8	—	20.9	—	29.1	—	54.7	—
	Net	16.1	—	14.7	—	17.8	—	20.9	—	29.1	—	54.7	—

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TABLE 132. *(Cont'd)* Incidence of Attended Illness or Preventive Care, by Diagnosis, by Age and Sex (and Adjusted to Age-Sex Composition of General Population)

Part II: Ages 20 and Over (Cont'd)

		NUMBER OF MEMBERS WITH INDICATED DIAGNOSIS PER 1,000 EXPOSURE YEARS											
		20–24		25–34		35–44		45–54		55–64		65 AND OVER	
DIAGNOSIS		M	F	M	F	M	F	M	F	M	F	M	F
XIV													
Diseases of Female Genital Organs and Breast (Excluding Neoplasms)	Gross	—	295.3	—	245.7	—	242.7	—	173.8	—	76.8	—	40.7
	Net	—	253.6	—	211.2	—	206.2	—	147.1	—	70.4	—	40.7
Diseases of Breast		—	17.3	—	12.8	—	14.4	—	15.2	—	6.4	—	2.9
Diseases of Ovaries, Fallopian Tubes and Parametrium		—	28.8	—	17.4	—	9.3	—	2.6	—	.8	—	0
Cervicitis		—	90.8	—	67.4	—	63.6	—	30.5	—	12.1	—	8.8
Vaginitis and Vulvitis		—	53.3	—	42.6	—	42.7	—	19.5	—	17.3	—	14.5
Menstrual Disorders		—	72.0	—	63.2	—	58.6	—	30.7	—	3.5	—	0
Menopausal Symptoms		—	1.4	—	1.2	—	20.1	—	54.9	—	21.9	—	0
Other		—	31.7	—	41.1	—	34.0	—	20.4	—	15.0	—	14.5
XV													
Deliveries and Complications of Pregnancy, Childbirth and Puerperium	Gross	—	256.5	—	186.7	—	47.5	—	2.3	—	0	—	0
	Net	—	250.7	—	182.9	—	47.5	—	2.3	—	0	—	0
Normal Deliveries		—	230.6	—	160.0	—	37.6	—	.9	—	0	—	0
Complicated Deliveries		—	4.3	—	3.1	—	.5	—	0	—	0	—	0
Abortion		—	17.3	—	20.1	—	8.5	—	1.4	—	0	—	0
Ectopic Pregnancy		—	0	—	.8	—	.3	—	0	—	0	—	0
Other		—	4.3	—	2.7	—	.6	—	0	—	0	—	0

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XVI													
Diseases of Skin and	Gross	179.7	164.3	125.3	117.8	104.3	117.9	92.4	118.6	75.7	105.1	88.7	72.7
Subcutaneous Tissues	Net	156.7	138.3	108.4	102.3	93.4	101.8	80.6	103.7	67.7	92.4	76.9	69.8
Boil and Carbuncle		20.7	8.6	16.0	8.5	11.2	9.6	11.0	8.0	9.6	8.1	10.3	5.8
Cellulitis		36.9	17.3	31.5	21.3	25.9	21.8	19.5	22.4	15.1	19.1	17.7	5.8
Impetigo		6.9	.4.3	.9	1.9	2.0	.8	.3	.6	.4	1.2	0	0
Infectious Wart		13.8	15.9	9.1	10.9	7.2	11.0	9.0	12.6	6.3	6.4	3.0	5.8
Dermatitis		39.2	37.5	20.3	32.2	20.6	32.3	19.2	28.4	17.1	24.8	25.1	20.3
Acne		18.4	20.2	2.1	5.8	.6	1.7	.6	.9	0	0	0	0
Sebaceous Cyst		11.5	11.5	12.1	7.4	10.6	6.8	9.0	9.5	6.4	4.6	8.9	5.8
Other		32.3	49.0	33.3	29.8	26.2	33.9	23.8	36.2	20.7	41.0	23.7	29.2
XVII													
Diseases of Bones and	Gross	48.4	67.7	82.1	80.6	104.6	128.4	127.8	156.9	117.5	168.0	145.0	206.4
Organs of Movement	Net	43.8	59.1	77.8	71.7	92.3	110.0	108.8	133.9	101.2	136.3	133.1	171.5
Arthritis and Rheumatism		6.9	10.1	16.4	17.8	25.9	38.2	37.3	55.4	44.2	71.0	66.6	93.0
Osteomyelitis and Other Diseases of Bones and Joints		4.6	8.7	6.5	5.2	8.4	10.2	11.9	15.2	9.2	17.3	16.3	29.1
Synovitis, Bursitis and Tenosynovitis		11.5	18.7	25.9	22.5	38.2	43.0	42.4	55.2	40.2	41.0	42.9	55.2
Infective Myositis		25.4	21.6	28.5	29.1	26.0	26.0	29.1	23.6	17.9	21.9	11.8	20.3
Muscular Dystrophy		0	0	0	0	0	0	.3	.3	0	.6	0	0
Scoliosis		0	1.4	.9	1.5	1.4	2.0	.6	.3	.8	1.2	0	2.9
Other Deformities		0	4.3	1.3	.4	1.1	2.2	1.7	2.3	1.6	5.8	1.5	0
Other Diseases of Musculoskeletal System		0	2.9	2.6	3.5	3.6	6.8	4.5	4.6	3.6	9.2	5.9	5.8

TABLE 132. *(Cont'd)* Incidence of Attended Illness or Preventive Care, by Diagnosis, by Age and Sex (and Adjusted to Age-Sex Composition of General Population)

Part II: Ages 20 and Over (Cont'd)

		NUMBER OF MEMBERS WITH INDICATED DIAGNOSIS PER 1,000 EXPOSURE YEARS											
		20–24		25–34		35–44		45–54		55–64		65 AND OVER	
DIAGNOSIS		*M*	*F*	*M*	*F*	*M*	*F*	*M*	*F*	*M*	*F*	*M*	*F*
XVIII													
Injuries and Adverse Effects	Gross	159.0	144.1	154.2	134.4	150.9	156.4	129.5	160.9	104.8	150.1	102.1	157.0
of External Causes	Net	140.6	129.7	135.6	119.7	135.2	139.1	121.6	134.2	92.0	125.3	85.8	133.7
	Gross	16.1	10.1	11.2	7.7	15.1	12.4	10.2	14.9	9.6	23.7	3.0	14.5
Fractures	Net	13.8	10.1	10.4	6.6	13.9	11.9	9.9	14.1	8.4	21.9	3.0	14.5
Skull and Face		2.3	0	1.7	.4	2.2	.8	.8	0	1.2	0	0	0
Torso	Gross	2.3	1.5	.9	1.5	1.7	1.7	3.7	3.1	2.4	4.6	1.5	0
Spine (Vertical Column)		2.3	0	0	.7	.6	1.4	.3	.5	0	2.9	0	0
Ribs, Sternum and Larynx		0	1.5	.9	.8	1.1	.3	3.4	2.6	2.4	1.7	1.5	0
UPPER EXTREMITIES	Gross	6.9	1.4	3.4	1.9	7.6	3.4	3.4	4.3	4.0	9.3	1.5	2.9
Clavicle		2.3	1.4	.8	.4	.3	.3	.3	.3	.4	0	0	0
Scapula		0	0	.4	0	.3	0	0	.3	0	0	0	0
Humerus		0	0	0	.4	.6	.3	.3	.3	.4	.6	1.5	0
Radius and Ulna		2.3	0	.4	0	1.1	0	1.1	1.1	.8	2.9	0	0
Wrist		2.3	0	0	.4	.3	.6	0	1.1	1.2	.6	0	2.9
Hand-Finger		0	0	1.8	.7	5.0	2.3	1.7	1.2	1.2	5.2	0	0
LOWER EXTREMITIES	Gross	4.6	7.2	5.2	3.9	3.6	6.2	2.3	7.5	2.0	9.2	0	11.6
Pelvis		0	0	0	.4	0	0	0	0	0	.6	0	0
Femur		0	0	0	0	0	0	0	.3	.4	1.7	0	8.7
Patella		0	0	0	0	0	0	.3	0	0	0	0	0
Tibia and Fibula		0	0	1.7	.8	.8	1.4	.3	1.8	.8	1.2	0	0
Ankle		0	1.4	1.3	.8	.6	1.7	0	1.4	.4	.6	0	0
Foot and Toe		4.6	5.8	2.2	1.9	2.2	3.1	1.7	4.0	.4	5.1	0	2.9
Late Effects of Fractures		0	0	0	0	0	.3	0	0	0	.6	0	0

Injuries (Cont'd)													
Dislocations		4.6	1.4	1.7	1.1	.8	1.7	2.0	1.2	.8	1.7	0	0
Sprains and Strains		43.8	54.8	65.2	56.6	71.4	64.8	61.6	63.8	42.6	46.8	32.5	40.7
Head Injuries (Other than Fractures)		6.9	2.9	5.2	3.9	4.7	2.0	5.7	2.9	4.4	5.2	4.4	11.6
Internal Injuries		0	1.4	0	1.1	0	0	0	0	.4	0	0	0
Lacerations and Open Wounds		32.3	37.5	28.4	21.7	22.9	22.3	14.4	21.6	12.8	13.8	10.3	23.3
Superficial Injuries		6.9	5.8	7.3	7.0	5.3	5.7	4.8	8.9	2.8	9.2	8.9	8.7
Foreign Body		2.3	0	6.5	3.1	5.0	4.0	4.8	3.4	2.4	2.9	0	5.8
Contusions		27.7	23.0	22.0	21.7	15.6	29.7	16.1	23.8	13.1	23.7	23.7	29.1
Complications of Surgical or Medical Procedures		2.3	7.2	2.6	7.4	4.5	9.3	6.8	16.1	11.1	16.2	16.3	14.6
Other		16.1	0	6.1	3.1	5.6	4.8	3.1	4.3	4.8	6.9	3.0	8.7
XIX	Gross	0	2.9	.9	.8	.8	1.1	.8	1.2	.8	1.2	1.5	0
Congenital Malformations	Net	0	2.9	.9	.8	.8	1.1	.8	1.2	.8	1.2	1.5	0
XX													
Certain Diseases of Early Infancy	Gross	—	—	—	—	—	—	—	—	—	—	—	—
	Net	—	—	—	—	—	—	—	—	—	—	—	—
XXI													
Symptoms, Senility and Ill-Defined Conditions	Gross	41.5	89.3	53.1	84.1	69.4	96.4	67.6	91.6	64.9	94.7	74.0	93.0
	Net	41.5	83.6	50.5	74.4	65.0	86.8	60.5	81.9	59.0	89.5	69.5	84.3
Symptoms Referrable to Nervous System		2.3	5.8	6.0	8.2	9.8	12.5	8.5	10.9	11.5	8.6	8.9	11.6
Symptoms Referrable to Cardiovascular System		2.3	10.1	2.2	5.8	5.8	12.5	6.5	14.7	6.4	11.0	11.8	8.7
Symptoms Referrable to Respiratory System		6.9	10.1	12.5	10.1	13.1	10.7	15.6	12.6	15.1	13.3	16.3	14.5
Symptoms Referrable to Upper and Lower Gastro-intestinal System		4.6	21.6	7.8	11.6	9.2	13.0	7.9	12.3	9.9	20.8	5.9	14.6
Symptoms Referrable to Urinary System		0	1.4	1.3	5.8	3.1	4.2	6.0	2.0	2.8	6.3	8.9	0
Pain in Back		2.3	11.5	3.9	6.2	5.0	8.2	6.2	8.0	8.6	5.8	5.9	14.6
Other Referrable Symptoms (Not Elsewhere Classified)		4.6	5.8	4.7	8.5	6.7	6.5	5.9	7.5	6.0	8.1	7.4	14.5
Headache		9.3	11.5	6.5	12.8	8.1	13.0	6.5	12.4	4.8	9.8	3.0	5.8
Other Ill-Defined Diseases		9.2	11.5	8.2	15.1	8.8	15.8	4.5	11.2	4.8	11.0	5.9	8.7

TABLE 132. *(Concluded)* Incidence of Attended Illness or Preventive Care, by Diagnosis, by Age and Sex (and Adjusted to Age-Sex Composition of General Population)

Part II: Ages 20 and Over (Concluded)

DIAGNOSIS		NUMBER OF MEMBERS WITH INDICATED DIAGNOSIS PER 1,000 EXPOSURE YEARS											
		20–24		25–34		35–44		45–54		55–64		65 AND OVER	
		M	F	M	F	M	F	M	F	M	F	M	F
XXII	Gross	50.7	125.4	70.8	120.5	69.4	93.0	65.6	77.3	65.3	75.1	51.8	64.0
Supplementary Classifications	Net	50.7	118.2	70.8	118.6	68.3	91.3	64.5	76.7	63.3	73.9	50.3	61.0
General Medical Examinations (Including Immunizations)		48.4	90.8	48.4	87.2	44.6	68.7	35.3	48.6	25.5	43.9	23.7	32.0
Well Baby and Child Care (Including Immunizations)		—	—	—	—	—	—	—	—	—	—	—	—
Diagnostic Screening		2.3	13.0	22.4	12.4	24.8	18.9	30.3	28.7	39.8	31.2	28.1	32.0
Other		—	21.6	—	20.9	—	5.4	—	0	—	0	—	0
XXIII	Gross	96.8	204.6	77.3	188.3	18.2	199.7	113.9	171.8	122.7	165.7	176.0	151.2
Undetermined Classifications	Net	96.8	204.6	77.3	188.3	18.2	199.7	113.9	171.8	122.7	165.7	176.0	151.2

* Less than .05.

† Gross rate is based on sum of patients reported for each component of a category; this represents duplicate count of persons treated for more than one condition in that category.

‡ Net rate is based on number of patients with *any* condition listed for a specified category.

§ Adjusted to age-sex composition of general population of area.

Category 2. Higher Blue-Collar Class Rates

In contrast to most diagnoses in the previous category, theories as to varying degrees of medical motivation do not generally emerge to explain instances where higher blue-collar class incidence rates occurred.

Members of blue-collar families were treated more frequently for infective diseases, tonsillitis, pneumonia, influenza, bronchitis, other respiratory conditions, gall bladder disorders, duodenal ulcers. It is probably reasonable to surmise that these conditions occurred more frequently, during the study year, among the blue-collar classes; but whether this is a regular occurrence and if so why must be left to further investigation. It is certainly difficult to reconcile the higher ulcer rates found for blue-collar members, particularly the 60 per cent higher rate of the males, with common assumptions as to greater ulcer susceptibility among those in positions of greatest responsibility.

Maternity care was used about 40 per cent more frequently in the blue-collar families. But it may be noteworthy that the reported abortion rate, in proportion to number of deliveries, was identical in the two groups discussed—one abortion to 7·53 deliveries.

Category 3. Class Differences Varying for Males and Females

The incidence of treated arthritis was a third higher among males of the blue-collar group than in the professional-executive-sales class.

Females of the latter class, however, experienced the highest rates—over 10 per cent higher than blue-collar class females.

A somewhat similar pattern was found for synovitis, and in fact for the total category of diseases of bones, joints and muscles.

The reverse pattern occurred for heart diseases. Here, the rate for males of the professional-executive-sales category was 25 per cent higher than among males of the blue-collar group, whereas treated incidence among females of the blue-collar

group was 50 per cent higher than among females of the professional-executive-sales group.

Still another pattern was found for a miscellaneous group of diagnoses in which males of different classes experienced similar rates, while females of the blue-collar group showed higher rates than those in the professional-executive-sales category. Examples include diabetes (blue-collar female rate nearly a third higher than professional-executive-sales females), hernia (blue-collar female rate over 80 per cent higher), liver

Class, by Diagnosis, by Sex and Class: Comparison of Professional-Executive-Sales and Blue-Collar Class Rates

DIAGNOSIS		NUMBER OF MEMBERS WITH INDICATED DIAGNOSIS PER 1,000 EXPOSURE YEARS, INCLUDING DEPENDENTS			
		MALE		FEMALE	
		Professional, Executive and Sales	*Blue Collar*	*Professional, Executive and Sales*	*Blue Collar*
TOTAL	Gross *	1923.5	1787.2	2301.8	2239.1
	Net †	771.4	733.1	841.3	847.5
I	Gross	74.5	108.3	121.9	126.0
Infective and Parasitic Diseases	Net	68.8	98.2	112.5	115.0
Streptococcal Sore Throat		9.8	15.5	17.8	19.5
Measles		3.6	6.8	6.7	6.1
Rubella (German Measles)		15.9	23.5	34.5	27.9
Chicken Pox		2.6	5.5	2.2	5.2
Mumps		1.6	3.4	3.9	3.8
Infectious Hepatitis		.5	.2	0	.2
Glandular Fever (Infectious Mononucleosis)		1.5	1.2	.6	1.8
Intestinal Virus		30.8	39.2	36.2	49.4
Dermatophytoses		3.1	7.0	8.3	5.0
Other		5.1	6.0	11.7	7.1
II	Gross	36.0	23.0	54.0	46.1
Neoplasms	Net	29.8	18.5	46.2	40.7
	Gross	11.3	5.4	7.8	6.2
Malignant Neoplasms	Net	9.2	4.1	6.7	5.3
Digestive System—Including Mouth		2.6	.7	0	.4
Respiratory System		1.5	1.0	1.1	.2
Breast		—	—	1.7	1.9
Female Genital Organs		—	—	1.1	.8
Male Genital Organs		0	.7	—	—
Urinary System		0	.8	0	0
Skin		2.6	.8	1.7	.3
Eye		0	0	.5	.1
Nervous System—Including Brain		1.0	.3	.5	.1
Endocrine Glands		0	.1	0	.3
Bone		0	.1	.8	.2
Connective Tissue		0	0	0	0
Lymphosarcoma		0	0	0	.1
Hodgkin's Disease		0	.1	0	.1
Other Lymphoma		.5	.2	0	0
Multiple Myeloma		0	.1	0	.1
Leukemia		.5	.1	0	.4
Not Elsewhere Classified		2.6	.8	.8	1.0
	Gross	23.7	15.4	44.5	37.7
Benign Neoplasms	Net	22.1	15.1	41.2	35.3
Mouth		1.6	.4	1.1	1.4
Rectum		1.5	.9	.5	.5
Breast		—	—	1.7	3.7
Female Genital Organs		—	—	15.6	15.3
Skin		13.4	8.7	18.4	10.3
Other		7.2	5.4	7.2	6.5

TABLE 133. *(Cont'd)*

DIAGNOSIS		NUMBER OF MEMBERS WITH INDICATED DIAGNOSIS PER 1,000 EXPOSURE YEARS, INCLUDING DEPENDENTS			
		MALE		FEMALE	
		Professional, Executive and Sales	*Blue Collar*	*Professional, Executive and Sales*	*Blue Collar*
Neoplasms (Cont'd)					
	Gross	1.0	1.2	1.7	2.2
Unspecified Neoplasms	Net	1.0	1.2	1.7	2.2
Rectum		0	0	0	.2
Breast		—	—	0	.8
Female Genital Organs		—	—	0	.3
Other		1.0	1.2	1.7	1.1
III					
Allergic, Endocrine System, Metabolic and Nutritional Diseases	Gross	90.4	70.8	126.4	116.7
	Net	81.7	63.9	110.8	104.5
Hay Fever		23.1	15.7	25.0	16.9
Asthma		13.9	14.0	13.4	13.2
Other Allergic Diseases		18.0	11.2	14.5	15.5
Diseases of Thyroid Gland		2.0	3.0	25.6	16.2
Diabetes Mellitus		11.3	10.9	5.8	9.1
Obesity (Not Otherwise Specified)		13.9	10.3	30.1	40.0
Other		8.2	5.7	12.2	6.0
IV					
Diseases of Blood and Blood Forming Organs	Gross	4.8	6.2	12.8	22.4
	Net	4.8	6.2	12.8	22.4
Anemias		4.1	4.8	12.2	20.9
Other		.5	1.8	.8	1.8
V					
Mental, Psychoneurotic and Personality Disorders	Gross	6.2	5.4	11.1	9.9
	Net	6.2	5.1	10.8	9.5
Chronic Brain Disorders		0	.8	.8	.1
Psychoses		.5	.7	1.1	1.5
Psychophysiologic, Autonomic and Visceral Disorders		0	.1	0	.2
Psychoneuroses		5.2	3.4	6.7	7.1
Personality Disorders		0	.4	2.2	.9
Mental Deficiency		.5	.2	.5	.1
VI	Gross	26.2	20.8	28.4	27.2
Diseases of Nervous System	Net	25.2	20.3	28.7	26.2
Stroke		0	.1	0	0
Multiple Sclerosis		.5	.1	0	.4
Migraine		3.1	2.0	5.0	4.8
Epilepsy		.5	.7	0	.7
Sciatica		4.1	3.9	1.7	4.7
Other		18.0	14.0	21.7	16.8
VII	Gross	67.8	44.8	69.1	50.5
Diseases of Eye	Net	63.7	41.6	65.1	47.2
Conjunctivitis and Ophthalmia		28.8	21.8	29.0	21.6
Strabismus		6.7	3.7	8.9	5.2
Cataract		1.5	1.9	0	2.2
Glaucoma		3.8	1.8	4.5	1.4
Detachment of Retina		0	.1	0	.2
Other		27.2	15.7	26.7	19.9

TABLE 133. (Cont'd) Incidence of Attended Illness or Preventive Care, by Diagnosis, by Sex and Class: Comparison of Professional-Executive-Sales and Blue-Collar Class Rates

DIAGNOSIS		NUMBER OF MEMBERS WITH INDICATED DIAGNOSIS PER 1,000 EXPOSURE YEARS, INCLUDING DEPENDENTS			
		MALE		FEMALE	
		Professional, Executive and Sales	*Blue Collar*	*Professional, Executive and Sales*	*Blue Collar*
VIII	Gross	63.7	67.8	74.6	73.0
Diseases of Ear	Net	59.6	63.6	68.5	67.0
Otitis Externa		7.7	8.1	7.2	9.4
Otitis Media		37.5	42.4	50.1	48.1
Deafness		1.0	.9	.6	1.1
Other		17.5	16.4	16.7	14.4
IX	Gross	104.8	94.5	90.2	106.6
Diseases of Circulatory System	Net	86.3	75.6	77.4	87.5
Rheumatic Fever without Mention of Heart		.5	.5	.6	.9
	Gross	50.9	40.4	21.7	38.3
Diseases of Heart	Net	38.5	29.4	18.4	25.8
Rheumatic Heart Disease		2.1	1.9	1.1	4.4
Arteriosclerotic Heart Disease		12.3	8.7	4.4	4.7
Acute Coronary Occlusion		4.1	4.8	1.7	1.3
Coronary Insufficiency		11.8	8.2	2.2	5.0
Angina Pectoris		5.1	6.6	2.8	4.5
Hypertensive Heart Disease		2.1	2.9	2.8	5.1
Other		13.4	7.3	6.7	7.3
Diseases of Veins and Arteries	Gross	53.4	53.6	67.9	73.4
(Other than Heart)	Net	51.4	51.9	62.9	68.5
Hypertensive Diseases		24.1	25.3	28.4	38.2
Hypotension		0	1.3	5.0	3.4
Hemorrhoids		14.9	10.3	10.0	10.1
General Arteriosclerosis		0	1.1	1.7	1.0
Varicose Veins of Lower Extremities		2.1	1.4	5.6	3.9
Pulmonary Embolism and Infarction		1.0	.2	0	.3
Lymphadenitis		3.6	7.6	6.1	6.9
Other		7.7	6.4	11.1	9.6
X	Gross	483.8	528.6	546.8	615.3
Diseases of Respiratory System	Net	351.8	370.4	378.6	430.6
Acute Nasopharyngitis		24.6	31.9	29.5	36.8
Pharyngitis		86.3	82.6	107.4	104.0
Tonsillitis		47.8	61.9	58.5	65.4
Hypertrophy of Tonsils		12.3	10.5	12.2	11.7
Laryngitis and Tracheitis		22.1	16.6	27.3	19.5
Sinusitis		23.6	19.1	31.2	23.9
Influenza		25.2	29.7	25.1	33.6
Pneumonia		7.7	11.3	8.3	12.6
Bronchitis		68.3	88.6	71.3	97.7
Other Diseases of Respiratory Tract		161.3	168.0	189.3	202.6
Diseases of Lungs		4.6	8.4	6.7	5.5

TABLE 133. *(Cont'd)*

DIAGNOSIS		NUMBER OF MEMBERS WITH INDICATED DIAGNOSIS PER 1,000 EXPOSURE YEARS, INCLUDING DEPENDENTS			
		MALE		FEMALE	
		Professional, Executive and Sales	*Blue Collar*	*Professional, Executive and Sales*	*Blue Collar*
XI	Gross	127.4	125.5	121.9	151.7
Diseases of the Digestive System	Net	113.0	108.9	105.8	128.8
Stomatitis		3.6	2.4	2.2	4.1
Other Diseases of Buccal Cavity and Esophagus		4.1	4.0	5.0	5.8
Ulcers		8.2	13.1	6.7	7.9
Gastritis and Duodenitis		17.0	20.2	18.9	23.6
Other Diseases of Stomach and Duodenum		6.2	4.2	7.8	4.7
Appendicitis		3.6	2.1	1.1	3.2
Hernia of Abdominal Cavity		8.7	7.8	2.8	5.1
Gastroenteritis and Colitis (Except Ulcerative)		48.8	47.5	51.2	65.4
Other Diseases of Intestines and Peritoneum		20.0	16.0	14.5	17.0
Diseases of Liver, Gall Bladder and	Gross	7.2	8.2	11.7	14.9
Pancreas	Net	7.2	7.8	11.7	14.5
Diseases of Liver		2.6	2.6	1.1	1.5
Diseases of Gall Bladder		3.6	4.8	10.0	12.3
Diseases of Pancreas		1.0	.8	.8	1.1
XII	Gross	18.5	19.6	36.8	36.3
Diseases of the Urinary System	Net	18.0	18.0	34.0	32.8
Nephritis and Nephrosis		0	.7	.8	1.4
Cystitis		6.2	7.5	24.5	21.1
Other		12.3	11.4	11.7	13.8
XIII					
Diseases of the Male Genital Organs	Gross	22.6	15.2	—	—
(Excluding Neoplasms)	Net	22.6	15.2	—	—
XIV					
Diseases of the Female Genital					
Organs and Breast (Excluding	Gross	—	—	132.0	124.9
Neoplasms)	Net	—	—	117.5	108.5
Diseases of Breast		—	—	10.0	8.6
Diseases of Ovaries, Fallopian Tubes and Parametrium		—	—	3.9	6.2
Cervicitis		—	—	32.3	29.5
Vaginitis and Vulvitis		—	—	19.5	20.1
Menstrual Disorders		—	—	34.0	27.2
Menopausal Symptoms		—	—	17.3	15.5
Other		—	—	15.0	17.8
XV					
Deliveries and Complications of					
Pregnancy, Childbirth and	Gross	—	—	29.0	41.3
Puerperium	Net	—	—	29.0	40.5
Normal Deliveries		—	—	24.5	35.3
Complicated Deliveries		—	—	0	.5
Abortion		—	—	3.4	4.9
Ectopic Pregnancy		—	—	0	.2
		—	—	1.1	.4

Care, by Diagnosis, by Sex and Class: Comparison of Professional-Executive-Sales and Blue-Collar Class Rates

DIAGNOSIS		NUMBER OF MEMBERS WITH INDICATED DIAGNOSIS PER 1,000 EXPOSURE YEARS, INCLUDING DEPENDENTS			
		MALE		FEMALE	
		Professional, Executive and Sales	*Blue Collar*	*Professional, Executive and Sales*	*Blue Collar*
XVI					
Diseases of Skin and Subcutaneous Tissues	Gross	135.1	107.2	138.6	111.4
	Net	117.6	98.1	125.8	98.2
Boil and Carbuncle		10.3	11.0	11.7	7.8
Cellulitis		24.7	21.4	20.0	19.5
Impetigo		5.6	5.7	5.8	4.7
Infectious Wart		12.8	8.9	17.8	9.3
Dermatitis		32.4	24.7	31.2	33.6
Acne		10.8	4.1	11.7	4.8
Sebaceous Cyst		8.7	6.1	7.8	4.8
Other		29.8	25.3	32.8	28.1
XVII					
Diseases of Bones and Organs of Movement	Gross	77.0	82.4	105.8	86.3
	Net	69.9	72.9	91.9	74.8
Arthritis and Rheumatism		16.9	22.4	31.2	27.9
Osteomyelitis and Other Diseases of Bones and Joints		9.8	8.4	7.8	8.1
Synovitis, Bursitis and Tenosynovitis		23.1	26.2	31.7	25.4
Infective Myositis		13.9	18.2	16.7	17.3
Muscular Dystrophy		0	.2	0	.1
Scoliosis		1.0	.6	3.4	1.0
Other Deformities		8.7	3.8	7.8	3.6
Other Diseases of Musculoskeletal System		3.8	2.6	7.2	2.9
XVIII					
Injuries and Adverse Effects of External Causes	Gross	203.4	159.5	162.0	134.5
	Net	174.1	139.8	145.1	117.4
	Gross	20.5	14.4	15.6	11.8
Fractures	Net	18.0	13.3	15.0	10.8
Skull and Face		2.5	1.9	1.1	.4
Torso	Gross	.5	1.5	1.7	1.5
Spine		0	.3	1.1	.5
Ribs, Sternum and Larynx		.5	1.3	.8	1.0
UPPER EXTREMITIES	Gross	11.3	7.5	8.4	4.6
Clavicle		0	.7	1.7	.5
Scapula		0	.1	0	0
Humerus		1.0	.7	.8	.2
Radius and Ulna		4.1	2.2	2.8	1.3
Wrist		1.8	.7	2.2	.8
Hand–Finger		4.6	3.1	1.1	2.0
LOWER EXTREMITIES	Gross	6.2	3.5	3.9	5.2
Pelvis		0	.1	.8	.1
Femur		.5	.1	.8	.3
Patella		.5	.3	0	0
Tibia and Fibula		1.0	1.1	1.1	1.4
Ankle		1.8	.3	.5	.9
Foot–Toe		2.8	1.8	1.1	2.8
Late Effects of Fractures		0	0	.5	.1

TABLE 133. *(Concluded)*

DIAGNOSIS		NUMBER OF MEMBERS WITH INDICATED DIAGNOSIS PER 1,000 EXPOSURE YEARS, INCLUDING DEPENDENTS			
		MALE		FEMALE	
		Professional, Executive and Sales	*Blue Collar*	*Professional, Executive and Sales*	*Blue Collar*
Injuries (Cont'd)					
Dislocations		2.6	2.1	2.2	1.6
Sprains and Strains		69.3	47.4	56.8	40.2
Head Injuries (Other than Fractures)		9.2	13.5	7.8	7.4
Internal Injuries		0	.3	0	.2
Lacerations and Open Wounds		37.0	34.4	29.5	25.7
Superficial Injuries		12.8	9.9	12.2	9.3
Foreign Body		5.7	3.8	6.1	3.8
Contusions		32.9	22.8	20.1	22.6
Complications of Surgical and Medical Procedures		6.7	5.0	7.8	7.4
Other		6.7	6.0	3.9	4.5
XIX	Gross	6.1	4.1	3.3	3.3
Congenital Malformations	Net	6.1	4.1	3.3	3.3
XX	Gross	0	1.0	1.1	1.0
Certain Diseases of Early Infancy	Net	0	1.0	1.1	1.0
XXI					
Symptoms, Senility and Ill-Defined Conditions	Gross	64.7	57.7	72.4	76.0
	Net	61.6	53.7	67.9	69.5
Symptoms Referrable to Nervous System		2.6	7.5	8.9	8.2
Symptoms Referrable to Cardiovascular System		6.7	4.2	5.6	8.6
Symptoms Referrable to Respiratory System		14.4	13.7	8.9	10.3
Symptoms Referrable to Upper and Lower Gastrointestinal System		10.3	8.2	11.7	12.3
Symptoms Referrable to Urinary System		3.6	3.1	1.7	3.4
Pain in Back		4.1	4.0	7.2	5.6
Other Referrable Symptoms (Not Elsewhere Classified)		8.2	7.5	12.8	8.6
Headache		9.3	5.2	5.6	9.8
Other Ill-Defined Diseases		5.6	4.3	10.0	9.2
XXII	Gross	170.5	148.0	186.5	165.7
Supplementary Classifications	Net	169.5	143.9	183.2	161.6
General Medical Examinations (Including Immunizations)		99.1	61.4	118.0	76.6
Well Baby and Child Care (Including Immunizations)		59.1	57.6	54.6	61.7
Other		12.3	29.0	13.9	27.4
XXIII					
Undetermined Classifications	Gross	140.2	97.8	177.1	133.0

* Gross rate is based on sum of patients reported for each component of a category; this represents duplicate count of persons treated for more than one condition in that category.

* Net rate is based on number of patients with any condition listed for a specified category.

conditions (blue-collar female rate about a fourth higher), anemias (blue-collar female rate about 70 per cent higher), sciatica (blue-collar female rate nearly triple), gastroenteritis and colitis (blue-collar female rate nearly 30 per cent higher).

No hypotheses as to the reasons for these findings are offered or even attempted. The usual cautionary reservation as to conclusions based on one year's multivariate analysis may be particularly applicable here.

* * *

The average obstetrical case involved 4.4 days of hospitalization, as against 8.4 days for non-maternity cases and 7.7 days for all cases (Table 139).

TABLE 139. Hospital Utilization Indices, by Type of Admission

TYPE OF CASE	NUMBER PER 1000 EXPOSURE YEARS *			Average Number of Days Per Admission
	Members Admitted	*Admissions*	*Hospital Days*	
All Cases	102.6	116.0	896.5	7.7
Non-Maternity	84.1	97.0	812.7	8.4
Surgical	48.9	55.1	378.7	6.9
Medical	35.2	41.9	434.0	10.4
Maternity	18.5	19.0	83.8	4.4

* Comprehensive and limited Plan samples.

The average stay of 7.7 days for GHI patients compares with averages of 8.1 nationally and 9.2, northeastern United States, reported by the National Center for Health Statistics.[1] The discrepancy in data coming from the two different types of sources may be related to age distribution differences as well as to the fact that insurance figures, by their nature, exclude most of the care rendered in government hospitals, where stays

tend to be much longer than in voluntary or proprietary hospitals. Blue Cross experience, not regularly published, happens to be available for 1964. When Blue Cross data rather than national health survey data are used as the basis of comparison, it is found that the GHI experience conformed rather closely: the GHI average stay for members under age 65 was 7.3 days, as against the Blue Cross figure of 7.6 in the Northeast, and 13.2 days for members aged 65 and over as against the Blue Cross figure of 13.4 in the Northeast, for the same period.[2]

[1] *Op. cit.*

[2] Passman, Mary Jane. *Hospitalization by Blue Cross Members in 1964, "Inquiry,"* Blue Cross Association, May 1966.

TABLE 147. Hospital Utilization, by Diagnosis: Frequency of Admissions and Days Per 1,000 Exposure Years [1]

DIAGNOSIS	Total Admissions Per 1,000 Exposure Years †	Total Days Per 1,000 Exposure Years †	TYPE OF ADMISSION: SURGICAL Admissions Per 1,000 Exposure Years	SURGICAL Days Per 1,000 Exposure Years	MEDICAL Admissions Per 1,000 Exposure Years	MEDICAL Days Per 1,000 Exposure Years
Combined Total	114.4	851.2	54.8	357.8	40.2	401.3
Infective and Parasitic Diseases	.9	8.8	—	—	.9	8.8
Streptococcal Sore Throat	.1	.5	—	—	.1	.5
Measles	0	0	—	—	0	0
Rubella (German Measles)	0 •	.1	—	—	0 •	.1
Chicken Pox	0	0	—	—	0	0
Mumps	0	0	—	—	0	0
Infectious Hepatitis	.1	2.1	—	—	.1	2.1
Glandular Fever (Infectious Mononucleosis)	.1	1.6	—	—	.1	1.6
Intestinal Virus	.4	2.4	—	—	.4	2.4
Dermatophytoses	0	0	—	—	0	0
Other	.2	2.1	—	—	.2	2.1
Neoplasms	10.6	93.0	8.9	73.3	1.7	19.7
Malignant Neoplasms	3.3	44.0	2.5	31.8	.8	12.2
Digestive System (Including Mouth)	.8	10.0	.5	9.1	.1	.9
Respiratory System	.8	7.3	.4	5.4	.2	1.8
Breast	.5	7.0	.4	6.4	.1	.8
Female Genital Organs	.4	3.8	.4	3.1	0 •	.7
Male Genital Organs	.3	5.3	.2	3.0	.1	2.3
Urinary System	.2	2.1	.2	2.1	0	0
Skin	.2	.7	.2	.7	0	0
Eye	0 •	.2	0 •	.2	0	0
Nervous System (Including Brain)	.1	1.1	.1	.4	0 •	.7
Endocrine Glands	0	0	0	0	0	0
Bone	0 •	.5	0	0	0 •	.5
Connective Tissue	0	0	0	0	0	0
Lymphosarcoma	0 •	.1	0 •	.1	0	0
Hodgkin's Disease	0 •	.2	0 •	.2	0	0
Other Lymphoma	.1	2.1	0 •	.3	.1	1.8
Multiple Myeloma	.1	1.2	0	0	.1	1.2
Leukemia	.1	1.5	0	0	.1	1.5
N.E.C.†	.1	1.1	.1	.8	0 •	.3
Benign Neoplasms	7.0	47.2	6.2	40.2	.8	6.4
Mouth	.2	.6	.2	.5	0 •	.1
Rectum	.3	3.0	.2	2.6	.1	.4
Breast	.7	3.4	.6	3.0	.1	.4
Female Genital Organs	2.9	27.2	2.7	25.5	.2	1.7
Skin	1.5	6.2	1.3	4.5	.2	1.7
Other	1.4	6.6	1.2	4.7	.2	2.1

TABLE 147. *(Cont'd)*

DIAGNOSIS	Total Admissions Per 1,000 Exposure Years †	Total Days Per 1,000 Exposure Years †	TYPE OF ADMISSION: SURGICAL Admissions Per 1,000 Exposure Years	SURGICAL Days Per 1,000 Exposure Years	MEDICAL Admissions Per 1,000 Exposure Years	MEDICAL Days Per 1,000 Exposure Years
Neoplasms (Cont'd)						
Unspecified Neoplasms	.3	1.8	.2	.7	.1	1.1
Rectum	0 •	.2	0 •	.2	0	0
Breast	0 •	.1	0 •	.1	0	0
Female Genital Organs	.1	.1	.1	.1	0	0
Other	.2	1.4	.1	.3	.1	1.1
Allergic, Endocrine System, Metabolic and Nutritional Diseases	3.0	30.9	.5	3.5	2.5	27.4
Hay Fever	0	0	0	0	0	0
Asthma	.6	5.9	0	0	.6	5.9
Other Allergic Diseases	.1	.5	0 •	.2	.1	.3
Diseases of Thyroid Gland	.7	5.4	.4	2.8	.3	2.6
Diabetes Mellitus	1.3	15.4	0	0	1.3	15.4
Obesity (N.O.S.) †	.1	1.6	0	0	.1	1.6
Other	.2	2.1	.1	.5	.1	1.6
Diseases of Blood and Blood-Forming Organs	.6	5.5	.1	.2	.5	5.3
Anemias	.4	3.6	0 •	0 •	.4	3.6
Other	.2	1.9	.1	.2	.1	1.7
Mental, Psychoneurotic and Personality Disorders †	.5	8.6	—	—	—	—
Diseases of the Nervous System	2.1	18.4	.6	3.1	1.5	15.3
Stroke	.1	.7	0 •	.1	.1	.6
Multiple Sclerosis	.1	1.3	0	0	.1	1.3
Migraine	0 •	.2	0	0	0 •	.2
Epilepsy	0 •	.1	0	0	0 •	.1
Sciatica	.2	2.6	0	0	.2	2.6
Other	1.7	13.5	.6	3.0	1.1	10.5
Diseases of the Eye	2.2	12.4	2.0	10.9	.2	1.5
Conjunctivitis and Ophthalmia	0 •	.2	0	0	0 •	.2
Strabismus	.6	1.7	.6	1.7	0	0
Cataract	.9	6.3	.8	6.2	.1	.1
Glaucoma	.2	.8	.2	.7	0 •	.1
Detachment of Retina	.1	2.6	.1	2.0	0 •	.6
Other	.4	.8	.3	.3	.1	.5

TABLE 147. *(Cont'd)* Hospital Utilization, by Diagnosis: Frequency of Admissions and Days Per 1,000 Exposure Years[1]

DIAGNOSIS	Total Admissions Per 1,000 Exposure Years †	Total Days Per 1,000 Exposure Years †	TYPE OF ADMISSION: SURGICAL Admissions Per 1,000 Exposure Years	SURGICAL Days Per 1,000 Exposure Years	MEDICAL Admissions Per 1,000 Exposure Years	MEDICAL Days Per 1,000 Exposure Years
Diseases of the Ear	1.2	6.7	.7	3.8	.5	2.9
Otitis Externa	0 *	.2	0	0	0 *	.2
Otitis Media	.4	1.7	.3	.5	.3	1.2
Deafness	0	0	0	0	0	0
Other	.8	4.8	.5	3.7	.3	2.1
Diseases of the Circulatory System	11.1	133.6	3.6	30.9	7.5	102.7
Rheumatic Fever without Mention of Heart	.1	2.0	0	0	.1	2.0
Diseases of the Heart	5.8	84.7	.4	8.7	5.4	76.0
Rheumatic Heart Disease	.7	9.4	.2	3.7	.5	5.7
Arteriosclerotic Heart Disease, So Described	1.0	16.7	0 *	.1	1.0	16.6
Acute Coronary Occlusion	1.2	23.9	0 *	.3	1.2	23.6
Coronary Insufficiency	1.1	10.6	0 *	.1	1.1	10.5
Angina Pectoris	.3	3.6	0	0	.3	3.6
Hypertensive Heart Disease	.3	2.3	0	0	.3	2.3
Other	1.2	18.2	.2	4.5	1.0	13.7
Diseases of Veins and Arteries (Other than the Heart)	5.2	46.9	3.2	22.2	2.0	24.7
Hypertensive Diseases	.7	9.1	.1	.4	.6	8.7
Hypotension	0	0	0	0	0	0
Hemorrhoids	1.8	11.7	1.8	11.3	0 *	.4
General Arteriosclerosis	.1	1.1	.1	1.1	0	0
Varicose Veins of Lower Extremities	.7	4.1	.7	4.0	0 *	.1
Pulmonary Embolism and Infarction	.1	1.8	0 *	.2	.1	1.6
Lymphadenitis	.4	1.7	.1	.4	.3	1.3
Other	1.4	17.4	.4	4.8	1.0	12.6
Diseases of the Respiratory System	14.5	58.2	9.9	17.5	4.6	41.7
Acute Nasopharyngitis	.1	.5	0	0	.1	.5
Pharyngitis	.2	2.1	0	0	.2	2.1
Tonsillitis	.7	2.7	.5	1.3	.2	1.4
Hypertrophy of Tonsils	8.0	8.2	8.0	8.2	0	0
Laryngitis and Tracheitis	.2	1.0	0 *	.2	.2	.8
Sinusitis	.2	1.5	.1	.9	.1	.6
Influenza	.1	.2	0	0	.1	.2
Pneumonia	2.1	22.2	.1	0 *	2.0	22.2
Bronchitis	.7	5.3	.1	.3	.6	5.0
Other Diseases of Upper Respiratory Tract	1.3	5.2	.9	3.3	.4	1.9
Diseases of Lungs	.9	9.3	.2	2.3	.7	7.0

TABLE 147. *(Cont'd)*

DIAGNOSIS	Total Admissions Per 1,000 Exposure Years †	Total Days Per 1,000 Exposure Years †	TYPE OF ADMISSION: SURGICAL Admissions Per 1,000 Exposure Years	SURGICAL Days Per 1,000 Exposure Years	MEDICAL Admissions Per 1,000 Exposure Years	MEDICAL Days Per 1,000 Exposure Years
Diseases of the Digestive System	16.3	151.1	9.3	91.2	7.0	59.9
Stomatitis	0 *	.1	0	0	0 *	.1
Other Diseases of Buccal Cavity and Esophagus	.2	.7	.1	.2	.1	.5
Ulcers	2.3	26.6	.6	10.1	1.7	16.5
Gastritis and Duodenitis	.8	4.7	.1	.4	.7	4.3
Other Diseases of Stomach and Duodenum	.1	.5	0 *	.1	.1	.4
Appendicitis	2.0	15.0	1.8	14.2	.2	.8
Hernia of Abdominal Cavity	3.5	28.7	3.2	26.5	.3	2.2
Gastroenteritis and Colitis (Except Ulcerative)	1.1	7.3	0	0	1.1	7.3
Other Diseases of Intestines and Peritoneum	2.8	23.2	1.4	10.4	1.4	12.8
Diseases of the Liver, Gall Bladder and Pancreas	3.5	44.3	2.1	29.3	1.4	15.0
Disease of the Liver	.6	7.1	0 *	.1	.6	7.0
Disease of the Gall Bladder	2.6	34.9	2.0	28.9	.6	6.0
Disease of the Pancreas	.3	2.3	.1	.3	.2	2.0
Diseases of the Urinary System	4.0	31.6	1.9	13.9	2.1	17.7
Nephritis and Nephrosis	.1	2.3	0	0	.1	2.3
Cystitis	1.1	6.1	.5	2.1	.6	4.0
Other	2.8	23.2	1.4	11.8	1.4	11.4
Diseases of the Male Genital Organs	1.7	13.2	1.6	12.2	.1	1.0
Diseases of the Female Genital Organs and Breast	5.8	36.4	5.1	31.6	.7	4.8
Diseases of the Breast	.8	3.3	.8	2.8	0 *	.5
Diseases of the Ovaries, Fallopian Tubes and Parametrium	.4	3.1	.2	1.9	.2	1.2
Cervicitis	1.0	7.1	.9	6.6	.1	.5
Vaginitis and Vulvitis	.1	.8	0 *	.3	.1	.5
Menstrual Disorders	1.4	5.3	1.3	4.8	.1	.5
Menopausal Symptoms	0	0	0	0	0	0
Other	2.1	16.8	1.9	15.4	.2	1.4
Deliveries and Complications of Pregnancy, Childbirth and Puerperium †	19.1	83.7	—	—	—	—

TABLE 147. *(Cont'd)* Hospital Utilization, by Diagnosis: Frequency of Admissions and Days Per 1,000 Exposure Years [1]

DIAGNOSIS	Total Admissions Per 1,000 Exposure Years †	Total Days Per 1,000 Exposure Years †	TYPE OF ADMISSION: SURGICAL Admissions Per 1,000 Exposure Years	SURGICAL Days Per 1,000 Exposure Years	MEDICAL Admissions Per 1,000 Exposure Years	MEDICAL Days Per 1,000 Exposure Years
Diseases of Skin and Subcutaneous Tissues	2.1	11.6	1.0	4.3	1.1	7.3
Boil and Carbuncle	.1	.8	0*	.1	.1	.7
Cellulitis	.8	4.8	.2	1.8	.4	3.0
Impetigo	0	0	0	0	0	0
Infectious Wart	.1	.7	.1	.2	0*	.5
Dermatitis	.1	.9	0	0	.1	.8
Acne	0	0	0	0	0	0
Sebaceous Cyst	.3	.4	.3	.4	0*	0*
Other	.9	4.0	.4	1.8	.5	2.8
Diseases of Bones and Organs of Movement	3.5	35.1	2.2	17.9	1.3	17.2
Arthritis and Rheumatism	.4	5.8	.1	.8	.3	5.0
Osteomyelitis and Other Diseases of Bones and Joints	1.5	20.8	.8	10.8	.7	10.0
Synovitis, Bursitis and Tenosynovitis	1.0	4.3	.8	3.0	.2	1.3
Infective Myositis	0*	.4	0	0	0*	.4
Muscular Dystrophy	0*	.3	0*	.1	0*	.2
Scoliosis	.1	.4	.1	.4	0	0
Other Deformities	.3	2.0	.3	2.0	0	0
Other Diseases of Musculoskeletal System	.2	1.1	.1	1.0	.1	.1
Injuries and Adverse Effects of External Causes	8.1	54.1	4.1	22.0	4.0	32.1
Fractures	3.0	24.2	2.4	14.5	.6	9.7
Skull and Face	.5	3.8	.3	.7	.2	2.9
Torso	.3	3.3	.1	1.0	.1	2.3
Spine (Vertebral Column)	.2	3.3	.1	1.0	.1	2.3
Ribs, Sternum and Larynx	0*	0*	0*	0*	0	0
Upper Extremities	1.3	6.1	1.2	5.3	.1	.8
Clavicle	.1	.9	.1	.4	0*	.5
Scapula	0*	.1	0*	.1	0	0
Humerus	.2	2.3	.2	2.3	0	0
Radius and Ulna	.7	2.0	.7	1.9	0*	.1
Wrist	.1	.4	.1	.4	0	0
Hand-Finger	.2	.4	.1	.2	.1	.2
Lower Extremities	1.0	11.2	.8	7.5	.2	3.7
Pelvis	0*	.3	0	0	0*	.3
Femur	.2	4.8	.2	2.4	0*	2.3
Patella	0	0	0	0	0	0
Tibia and Fibula	.4	1.9	.4	1.8	0*	.2
Ankle	.2	2.2	.1	1.5	.1	.7
Foot-Toe	.2	2.2	.1	2.0	.1	.2
Late Effects of Fractures	0	0	0	0	0	0

TABLE 147. *(Concluded)*

DIAGNOSIS	Total Admissions Per 1,000 Exposure Years †	Total Days Per 1,000 Exposure Years †	TYPE OF ADMISSION: SURGICAL Admissions Per 1,000 Exposure Years	SURGICAL Days Per 1,000 Exposure Years	MEDICAL Admissions Per 1,000 Exposure Years	MEDICAL Days Per 1,000 Exposure Years
Injuries (Cont'd)						
Dislocations	.3	1.6	.2	1.1	.1	.5
Sprains and Strains	1.3	9.8	.1	.7	1.2	9.1
Head Injuries (Other than Fractures)	1.0	5.3	.1	.9	.9	4.4
Internal Injuries	.1	.5	.1	.5	0	0
Lacerations and Open Wounds	1.0	3.5	.8	2.7	.2	.8
Superficial Injuries	.1	.5	0*	.2	.1	.3
Foreign Body	.1	.3	.1	.1	0*	.2
Contusions	.7	5.8	.1	.7	.6	4.9
Complications of Surgical or Medical Procedures	.1	.5	.1	.2	0*	.3
Other	.4	2.3	.1	.4	.3	1.9
Congenital Malformations	.8	6.3	.7	5.0	.1	1.3
Certain Diseases of Early Infancy	.5	5.4	.1	.5	.4	4.9
Symptoms, Senility and Ill-Defined Conditions	2.6	18.7	.5	3.8	2.1	14.9
Symptoms Referrable to Nervous System	.3	1.9	0*	.2	.3	1.7
Symptoms Referrable to Cardiovascular System	.2	.7	0	0	.2	.7
Symptoms Referrable to Respiratory System	.5	2.9	.1	.5	.4	2.4
Symptoms Referrable to Upper and Lower Gastrointestinal System	.5	5.7	0*	.4	.5	5.3
Symptoms Referrable to Urinary System	.4	2.7	.1	1.0	.3	1.7
Pain in Back	.1	.4	0	0	.1	.4
Other Referrable Symptoms, N.E.C.‡	.5	3.8	.2	1.1	.3	2.5
Headache	0	0	0	0	0	0
Other Ill-Defined Diseases	.1	.8	.1	.6	0*	.2
Undetermined Classifications	3.3	28.5	1.8	12.4	1.4	14.5

[1] Comprehensive Plan sample.

* Less than .05.

† Including in addition to surgical and medical admissions, 19.1 obstetrical admissions and 83.7 obstetrical days, and .3 psychiatric admissions and 8.6 psychiatric days, per 1,000 exposure years. Of the obstetrical admissions, 16.5 were for normal deliveries, 2.3 for abortions or miscarriages, .3 for complicated deliveries or ectopic pregnancies.

‡ Not elsewhere classified or otherwise specified.

HOSPITALIZATION: DISTRIBUTION OF ADMISSIONS AND AGGREGATE DAYS, BY LENGTH OF STAY, BY TYPE OF ADMISSION

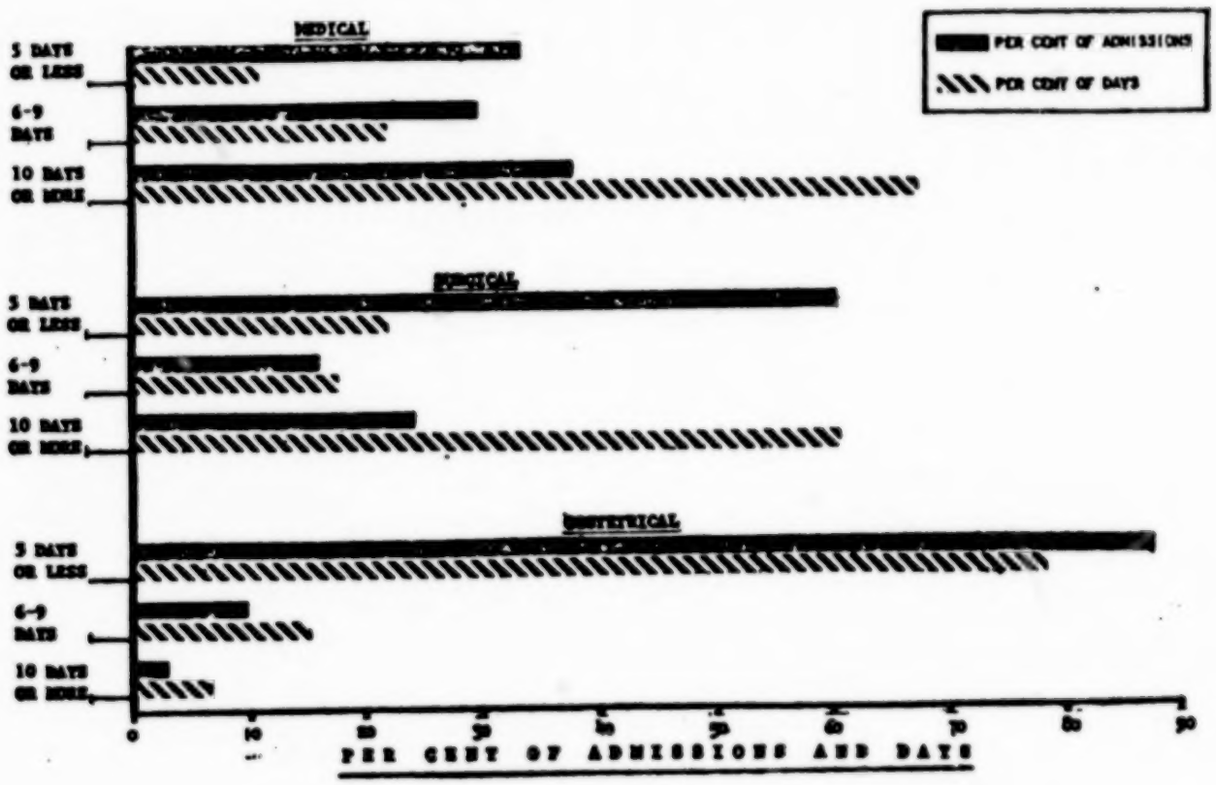

TABLE 161. Distribution of Hospital Admissions and Days by Diagnostic Category, by Type of Admission

DIAGNOSTIC CATEGORY	ALL		TYPE OF ADMISSION *							
			MEDICAL		SURGICAL		OBSTETRICAL			
	Admissions	Days	Admissions	Days	Admissions	Days	Admissions	Days		
	%	%	%	%	%	%	%	%		
Infective and Parasitic Diseases	.5	1.1	.2	.1	0	0				
Neoplasms	9.5	11.0	2.3	2.3	16.2	20.3				
Allergic, Endocrine System, Metabolic and Nutritional Diseases	2.5	3.9	4.4	5.2						
Diseases of Blood and Blood-Forming Organs	.5	.7	.5	.7	.1	.1				
Diseases of Nervous System	1.9	2.3	1.3	1.4	.9	.9				
Diseases of the Eye	2.0	1.5	4.0	4.0	1.1	3.2				
Diseases of the Ear	1.1	.5	.5	.4	3.8	1.0				
Diseases of the Circulatory System	10.1	16.5	1.2	.9	1.4	9.2				
Diseases of the Respiratory System	13.1	7.3	10.2	26.5	7.1	5.2				
Diseases of the Digestive System	14.8	18.6	11.8	10.7	18.8	26.5				
Diseases of the Urinary System	3.7	3.9	18.1	15.5	17.7	4.0				
Diseases of the Male Genital Organs	1.5	1.6	5.4	4.6	3.7	3.5				
Diseases of the Female Genital Organs and Breast	5.2	4.5	.3	.3	2.9		100.0	100.0		
Deliveries and Complications of Pregnancy, Childbirth and Puerperium	17.2	10.2	1.6	1.3	9.8	9.3				
Diseases of Skin and Subcutaneous Tissue	1.9	1.4	0	0	0	0	100.0	100.0		
Diseases of Bones and Organs of Movement	3.2	4.3	2.8	1.9	2.0	1.3				
Congenital Malformations	.8	.8	3.4	4.4	4.2	5.3				
Certain Diseases of Early Infancy	.5	.7	.3	.3	1.3	1.5				
Symptoms, Senility and Ill-Defined Conditions	2.4	2.3	1.1	1.3	.1	.1				
Injuries and Adverse Effects of External Causes	7.3	6.0	5.5	3.8	.9	1.1				
TOTAL	100.0	100.0	10.3	8.2	7.8	6.4				
			100.0	100.0	100.0	100.0	100.0	100.0		

* Comprehensive Plan sample, excluding psychiatric admissions.

TABLE 162. Average Length of Stay, Surgical and Medical Admissions, by Major Diagnostic Categories

DIAGNOSTIC CATEGORY	NUMBER OF DAYS PER STAY		
	Hospital Admissions *	Surgical Admissions	Medical Admissions
Infective and Parasitic Diseases	9.9	—	9.9
Neoplasms	8.8	8.2	11.8
Allergic, Endocrine System, Metabolic and Nutritional Diseases	10.4	7.5	11.0
Diseases of Blood and Blood-Forming Organs	9.4	2.0	10.8
Diseases of the Nervous System	8.8	5.4	10.0
Diseases of the Eye	5.8	5.4	6.9
Diseases of the Ear	5.8	4.5	7.5
Diseases of the Circulatory System	12.0	8.5	13.8
Diseases of the Respiratory System	4.1	1.7	9.0
Diseases of the Digestive System	9.3	9.8	8.5
Diseases of the Urinary System	7.8	7.1	8.5
Diseases of the Male Genital Organs	8.0	7.8	8.8
Diseases of the Female Genital Organs and Breast	6.3	6.3	7.8
Deliveries and Complications of Pregnancy, Childbirth and Puerperium	4.4	—	—
Diseases of Skin and Subcutaneous Tissues	5.4	3.9	6.8
Diseases of Bones and Organs of Movement	10.1	8.3	13.1
Congenital Malformations	7.7	6.9	11.8
Certain Diseases of Early Infancy	10.4	6.5	11.0
Symptoms, Senility and Ill-Defined Conditions	7.1	7.7	7.0
Injuries and Adverse Effects of External Causes	6.7	5.3	8.0
TOTAL, Excluding Maternity	8.0	6.5	10.0
TOTAL, Including Maternity	7.4	—	—

* Comprehensive Plan sample, excluding psychiatric admissions.

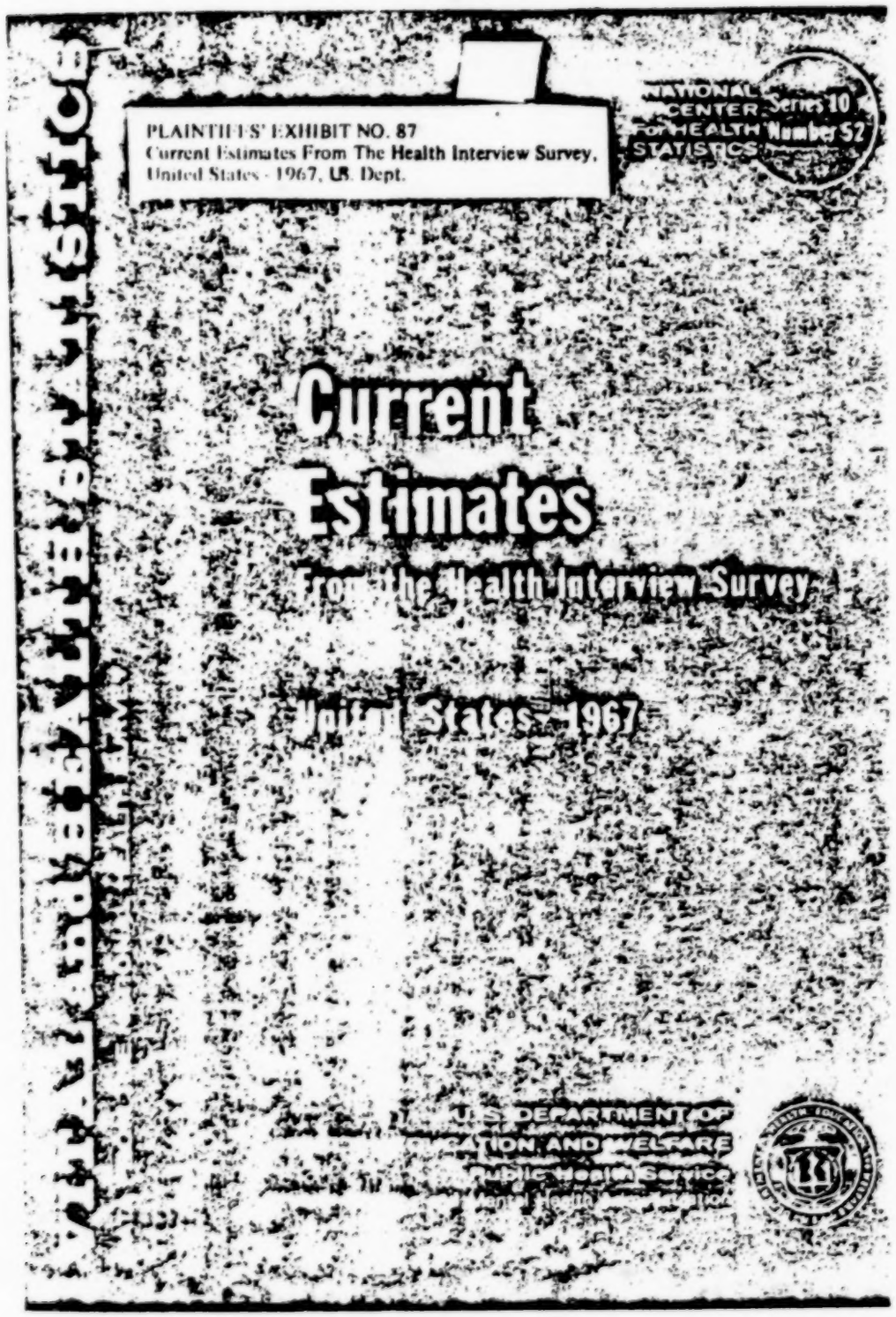

TABLE 1. INCIDENCE OF ACUTE CONDITIONS, PERCENT DISTRIBUTION, AND NUMBER OF ACUTE CONDITIONS PER 100 PERSONS PER YEAR, BY SEX AND CONDITION GROUP: UNITED STATES, 1967

[Data are based on household interviews of the civilian, noninstitutional population. The survey design, general qualifications, and information on the reliability of the estimates are given in Appendix I. Definitions of terms are given in Appendix II]

CONDITION GROUP	BOTH SEXES	MALE	FEMALE	BOTH SEXES	MALE	FEMALE	BOTH SEXES	MALE	FEMALE
	INCIDENCE OF ACUTE CONDITIONS IN THOUSANDS			PERCENT DISTRIBUTION			NUMBER OF ACUTE CONDITIONS PER 100 PERSONS PER YEAR		
ALL ACUTE CONDITIONS	367,453	170,606	196,847	100.0	100.0	100.0	190.0	183.0	196.9
INFECTIVE AND PARASITIC DISEASES	44,174	21,153	23,020	12.0	12.4	11.7	22.8	22.7	23.0
COMMON CHILDHOOD DISEASES	8,884	4,609	4,275	2.4	2.7	2.2	4.6	4.9	4.3
THE VIRUS, N.O.S.	26,662	11,978	14,684	7.3	7.0	7.4	13.8	12.9	14.6
OTHER INFECTIVE AND PARASITIC DISEASES	8,648	4,567	4,081	2.4	2.7	2.1	4.5	4.9	4.1
RESPIRATORY CONDITIONS	204,581	93,951	110,630	55.7	55.1	56.2	105.8	100.8	110.4
UPPER RESPIRATORY CONDITIONS	132,318	61,037	71,280	36.0	35.8	36.2	68.4	65.5	71.1
COMMON COLD	103,513	47,519	55,998	28.2	27.9	28.4	53.5	51.0	55.9
OTHER ACUTE UPPER RESPIRATORY CONDITIONS	28,805	13,522	15,283	7.8	7.9	7.8	14.9	14.5	15.3
INFLUENZA	64,760	29,092	35,668	17.6	17.1	18.1	33.5	31.2	35.6
INFLUENZA WITH DIGESTIVE MANIFESTATIONS	8,975	4,093	4,882	2.4	2.4	2.5	4.6	4.4	4.9
OTHER INFLUENZA	55,785	24,999	30,786	15.2	14.7	15.6	28.8	26.8	30.7
OTHER RESPIRATORY CONDITIONS	7,504	3,822	3,682	2.0	2.2	1.9	3.9	4.1	3.7
PNEUMONIA	2,110	1,205	905	0.6	0.7	0.5	1.1	1.3	0.9
BRONCHITIS	3,719	1,822	1,897	1.0	1.1	1.0	1.9	2.0	1.9
OTHER ACUTE RESPIRATORY CONDITIONS	1,675	795	*	0.5	0.5	*	0.9	0.9	*
DIGESTIVE SYSTEM CONDITIONS	16,538	7,836	8,702	4.5	4.6	4.4	8.6	8.4	8.7
DENTAL CONDITIONS	5,671	2,360	3,311	1.5	1.4	1.7	2.9	2.5	3.3
FUNCTIONAL AND SYMPTOMATIC UPPER GASTROINTESTINAL DISORDERS, N.E.C.	3,533	1,495	2,038	1.0	0.9	1.0	1.8	1.6	2.0
OTHER DIGESTIVE SYSTEM CONDITIONS	7,334	3,980	3,354	2.0	2.3	1.7	3.8	4.3	3.3
INJURIES	55,503	31,709	23,794	15.1	18.6	12.1	28.7	34.0	23.7
FRACTURES, DISLOCATIONS, SPRAINS, AND STRAINS	18,124	9,270	8,855	4.9	5.4	4.5	9.4	9.9	8.8
FRACTURES AND DISLOCATIONS	5,554	3,233	2,322	1.5	1.9	1.2	2.9	3.5	2.3
SPRAINS AND STRAINS	10,570	6,037	4,533	2.9	3.5	2.3	5.5	6.5	4.5
OPEN WOUNDS AND LACERATIONS	15,721	9,455	6,266	4.3	5.5	3.2	8.1	10.1	6.3
CONTUSIONS AND SUPERFICIAL INJURIES	10,006	4,992	5,013	2.7	2.9	2.5	5.2	5.4	5.0
OTHER CURRENT INJURIES	13,652	7,992	5,660	3.7	4.7	2.9	7.1	8.6	5.6
ALL OTHER ACUTE CONDITIONS	48,657	15,957	30,701	12.7	9.4	15.6	24.1	17.1	30.6
DISEASES OF THE EAR	9,115	4,554	4,561	2.5	2.7	2.3	4.7	4.9	4.6
HEADACHES	3,428	860	2,568	0.9	0.5	1.3	1.8	0.9	2.6
GENITOURINARY DISORDERS	6,129	723	5,407	1.7	0.4	2.7	3.2	0.8	5.4
DELIVERIES AND DISORDERS OF PREGNANCY AND THE PUERPERIUM	4,252	...	4,252	1.2	...	2.2	2.2	...	4.2
DISEASES OF THE SKIN	5,047	2,054	2,993	1.4	1.2	1.5	2.6	2.2	3.0
DISEASES OF THE MUSCULOSKELETAL SYSTEM	4,202	1,528	2,674	1.1	0.9	1.4	2.2	1.6	2.7
ALL OTHER ACUTE CONDITIONS	14,483	6,237	8,245	3.9	3.7	4.2	7.5	6.7	8.2

NOTE: Excluded from these statistics are all conditions involving neither restricted activity nor medical attention.

N.o.s.—not otherwise specified; n.e.c.—not elsewhere classified.

TABLE 2. INCIDENCE OF ACUTE CONDITIONS AND NUMBER OF ACUTE CONDITIONS PER 100 PERSONS PER YEAR, BY AGE, SEX, AND CONDITION GROUP: UNITED STATES, 1967

[Data are based on household interviews of the civilian, noninstitutional population. The survey design, general qualifications, and information on the reliability of the estimates are given in Appendix I. Definitions of terms are given in Appendix II]

SEX AND CONDITION GROUP	ALL AGES	UNDER 6	6-16	17-44	45 & OVER	ALL AGES	UNDER 6	6-16	17-44	45 & OVER
	INCIDENCE OF ACUTE CONDITIONS IN THOUSANDS					NUMBER OF ACUTE CONDITIONS PER 100 PERSONS PER YEAR				
BOTH SEXES										
ALL ACUTE CONDITIONS	267,453	78,287	99,166	121,466	68,494	190.0	334.7	227.0	176.8	118.9
INFECTIVE AND PARASITIC DISEASES	44,174	11,449	15,679	12,041	5,005	22.8	48.9	35.9	17.5	8.7
RESPIRATORY CONDITIONS	204,581	48,546	58,314	64,252	37,469	105.8	199.0	128.9	93.5	65.1
UPPER RESPIRATORY CONDITIONS	132,314	35,433	37,211	37,652	22,021	68.4	151.5	85.2	54.8	38.2
INFLUENZA	64,760	8,485	17,562	24,656	14,077	33.5	36.2	40.2	35.9	24.4
OTHER RESPIRATORY CONDITIONS	7,504	2,648	1,541	1,943	1,372	3.9	11.3	3.5	2.8	2.4
DIGESTIVE SYSTEM CONDITIONS	16,538	3,267	3,475	5,573	3,719	8.6	14.0	9.1	8.1	6.5
INJURIES	55,503	6,922	13,168	20,989	12,424	28.7	38.1	30.1	30.5	21.6
ALL OTHER ACUTE CONDITIONS	46,657	8,103	10,646	18,631	9,877	24.1	34.6	23.0	27.1	17.1
MALE										
ALL ACUTE CONDITIONS	170,606	40,977	51,083	48,600	29,966	183.0	342.5	230.6	150.1	112.1
INFECTIVE AND PARASITIC DISEASES	21,153	6,087	8,394	4,733	1,940	22.7	50.9	37.9	14.6	7.3
RESPIRATORY CONDITIONS	93,951	23,893	27,830	25,646	16,582	100.8	199.7	125.7	79.2	62.0
UPPER RESPIRATORY CONDITIONS	61,037	18,112	17,972	15,447	9,507	65.5	151.4	81.2	47.7	35.6
INFLUENZA	26,092	4,161	9,020	9,437	6,474	31.2	34.8	40.7	29.2	24.2
OTHER RESPIRATORY CONDITIONS	3,822	1,620	836	762	*	4.1	13.5	3.8	2.4	*
DIGESTIVE SYSTEM CONDITIONS	7,836	1,774	1,917	2,267	1,878	8.4	14.8	8.7	7.0	7.0
INJURIES	31,709	5,229	8,457	12,094	5,929	34.0	43.7	38.2	37.4	22.2
ALL OTHER ACUTE CONDITIONS	15,957	3,994	4,486	3,860	3,636	17.1	33.4	20.7	11.9	13.6
FEMALE										
ALL ACUTE CONDITIONS	196,847	37,309	48,123	72,886	38,529	196.5	326.5	223.4	200.5	124.8
INFECTIVE AND PARASITIC DISEASES	23,020	5,362	7,285	7,308	3,065	23.0	46.9	33.8	20.1	9.9
RESPIRATORY CONDITIONS	110,630	22,653	28,484	38,606	20,887	110.4	198.2	132.2	106.2	67.7
UPPER RESPIRATORY CONDITIONS	71,280	17,321	19,239	22,206	12,514	71.1	151.6	89.3	61.1	40.5
INFLUENZA	38,668	4,324	8,542	15,220	7,662	35.6	37.7	39.6	41.9	24.8
OTHER RESPIRATORY CONDITIONS	3,682	1,028	702	1,181	771	3.7	9.0	3.3	3.2	2.5
DIGESTIVE SYSTEM CONDITIONS	8,702	1,493	2,062	3,306	1,841	8.7	13.1	9.6	9.1	6.0
INJURIES	23,794	3,693	4,712	8,895	6,494	23.7	32.3	21.9	24.5	21.0
ALL OTHER ACUTE CONDITIONS	30,701	4,109	5,581	14,771	6,241	30.6	36.0	25.9	40.6	20.2

NOTE: Excluded from these statistics are all conditions involving neither restricted activity nor medical attention.

TABLE 3. DAYS OF RESTRICTED ACTIVITY ASSOCIATED WITH ACUTE CONDITIONS AND DAYS OF RESTRICTED ACTIVITY PER 100 PERSONS PER YEAR, BY SEX AND CONDITION GROUP: UNITED STATES, 1967

[Data are based on household interviews of the civilian, noninstitutional population. The survey design, general qualifications, and information on the reliability of the estimates are given in Appendix I. Definitions of terms are given in Appendix II]

CONDITION GROUP	BOTH SEXES	MALE	FEMALE	BOTH SEXES	MALE	FEMALE
	DAYS OF RESTRICTED ACTIVITY IN THOUSANDS			DAYS OF RESTRICTED ACTIVITY PER 100 PERSONS PER YEAR		
ALL ACUTE CONDITIONS	1,455,388	638,154	816,934	752.4	684.6	815.4
INFECTIVE AND PARASITIC DISEASES	177,177	85,914	91,263	91.6	92.2	91.1
COMMON CHILDHOOD DISEASES	54,269	26,579	25,690	28.1	30.7	25.6
THE VIRUS, N.E.C.S.	79,628	34,894	44,734	41.2	37.4	44.6
OTHER INFECTIVE AND PARASITIC DISEASES	43,280	22,441	20,839	22.4	24.1	20.8
RESPIRATORY CONDITIONS	655,665	288,295	367,370	338.8	307.1	366.7
UPPER RESPIRATORY CONDITIONS	352,180	158,736	193,444	182.1	170.3	193.1
COMMON COLD	266,187	120,722	145,464	137.6	129.5	145.2
OTHER ACUTE UPPER RESPIRATORY CONDITIONS	85,993	38,014	47,980	44.5	40.8	47.9
INFLUENZA	241,622	99,758	141,919	124.9	107.0	141.6
INFLUENZA WITH DIGESTIVE MANIFESTATIONS	25,466	11,342	14,123	13.2	12.2	14.1
OTHER INFLUENZA	216,157	88,386	127,791	111.8	94.8	127.5
OTHER RESPIRATORY CONDITIONS	59,862	27,851	32,011	31.0	29.9	31.9
PNEUMONIA	29,441	12,894	16,547	15.2	13.8	16.5
BRONCHITIS	25,820	12,736	13,083	13.4	13.7	13.1
OTHER ACUTE RESPIRATORY CONDITIONS	4,602	2,221	2,381	2.4	2.4	2.4
DIGESTIVE SYSTEM CONDITIONS	67,964	31,251	36,712	35.1	33.5	36.6
DENTAL CONDITIONS	17,922	6,402	11,521	9.3	6.9	11.5
FUNCTIONAL AND SYMPTOMATIC UPPER GASTROINTESTINAL DISORDERS, N.E.C.	7,277	3,291	3,986	3.8	3.5	4.0
OTHER DIGESTIVE SYSTEM CONDITIONS	42,764	21,558	21,206	22.1	23.1	21.2
INJURIES	332,688	169,824	162,864	171.7	182.2	162.0
FRACTURES, DISLOCATIONS, SPRAINS, AND STRAINS	183,387	92,308	91,079	94.8	99.0	90.9
FRACTURES AND DISLOCATIONS	107,990	53,454	54,536	55.8	57.3	54.4
SPRAINS AND STRAINS	75,397	38,854	36,543	39.0	41.7	36.5
OPEN WOUNDS AND LACERATIONS	48,157	28,088	20,070	24.9	30.1	20.0
CONTUSIONS AND SUPERFICIAL INJURIES	49,569	19,100	26,468	23.6	20.5	26.4
OTHER CURRENT INJURIES	54,974	30,327	24,647	28.4	32.5	24.6
ALL OTHER ACUTE CONDITIONS	224,195	84,870	139,325	115.9	89.4	139.0
DISEASES OF THE EAR	31,134	15,665	15,438	16.1	16.8	15.4
HEADACHES	4,342	1,788	2,554	2.2	1.9	2.5
GENITOURINARY DISORDERS	34,431	5,298	29,132	17.8	5.7	29.1
ABORTIONS AND DISORDERS OF PREGNANCY AND THE PUERPERIUM	41,830	---	41,830	21.6	---	41.8
DISEASES OF THE SKIN	14,864	5,071	9,593	7.6	5.4	9.6
DISEASES OF THE MUSCULOSKELETAL SYSTEM	27,318	8,891	18,427	14.1	9.5	18.4
ALL OTHER ACUTE CONDITIONS	70,507	28,157	42,350	36.5	30.2	42.3

NOTE: N.o.s.—not otherwise specified; n.e.c.—not elsewhere classified.

TABLE 4. DAYS OF BED DISABILITY ASSOCIATED WITH ACUTE CONDITIONS AND DAYS OF BED DISABILITY PER 100 PERSONS PER YEAR, BY SEX AND CONDITION GROUP: UNITED STATES 1967

[Data are based on household interviews of the civilian, noninstitutional population. The survey design, general qualifications, and information on the reliability of the estimates are given in Appendix I. Definitions of terms are given in Appendix II]

CONDITION GROUP	BOTH SEXES	MALE	FEMALE	BOTH SEXES	MALE	FEMALE
	DAYS OF BED DISABILITY IN THOUSANDS			DAYS OF BED DISABILITY PER 100 PERSONS PER YEAR		
ALL ACUTE CONDITIONS	611,158	264,635	346,523	316.0	283.9	345.9
INFECTIVE AND PARASITIC DISEASES	84,496	39,792	44,704	43.7	42.7	44.6
COMMON CHILDHOOD DISEASES	20,157	9,127	11,030	10.4	9.8	11.0
THE VIRUS, N.E.C.S.	41,872	18,163	23,708	21.7	19.5	23.7
OTHER INFECTIVE AND PARASITIC DISEASES	22,466	12,501	9,967	11.6	13.4	9.9
RESPIRATORY CONDITIONS	315,636	138,761	176,875	163.2	148.9	176.5
UPPER RESPIRATORY CONDITIONS	149,469	67,945	81,524	77.3	72.9	81.4
COMMON COLD	109,576	50,114	59,460	56.7	53.8	59.3
OTHER ACUTE UPPER RESPIRATORY CONDITIONS	39,896	17,831	22,065	20.6	19.1	22.0
INFLUENZA	132,857	55,203	77,654	68.7	59.2	77.5
INFLUENZA WITH DIGESTIVE MANIFESTATIONS	14,059	6,788	7,271	7.3	7.3	7.3
OTHER INFLUENZA	118,798	48,416	70,383	61.4	51.9	70.2
OTHER RESPIRATORY CONDITIONS	33,310	15,612	17,697	17.2	16.7	17.7
PNEUMONIA	16,936	8,138	8,799	8.8	8.7	8.8
BRONCHITIS	15,077	7,044	8,032	7.8	7.6	8.0
OTHER ACUTE RESPIRATORY CONDITIONS	*	*	*	*	*	*
DIGESTIVE SYSTEM CONDITIONS	33,287	16,021	17,266	17.2	17.2	17.2
DENTAL CONDITIONS	7,363	3,263	4,101	3.9	3.5	4.1
FUNCTIONAL AND SYMPTOMATIC UPPER GASTROINTESTINAL DISORDERS, N.E.C.	3,960	2,021	1,939	2.0	2.2	1.9
OTHER DIGESTIVE SYSTEM CONDITIONS	21,964	10,737	11,226	11.4	11.5	11.2
INJURIES	88,651	44,432	44,220	45.8	47.7	44.1
FRACTURES, DISLOCATIONS, SPRAINS, AND STRAINS	44,882	22,573	22,309	23.2	24.2	22.3
FRACTURES AND DISLOCATIONS	28,472	14,909	13,563	14.7	16.0	13.5
SPRAINS AND STRAINS	16,410	7,664	8,746	8.5	8.2	8.7
OPEN WOUNDS AND LACERATIONS	9,459	4,884	4,575	4.9	5.2	4.6
CONTUSIONS AND SUPERFICIAL INJURIES	13,456	5,302	8,154	7.0	5.7	8.1
OTHER CURRENT INJURIES	20,855	11,672	9,183	10.8	12.5	9.2
ALL OTHER ACUTE CONDITIONS	89,387	25,630	63,457	46.1	27.5	63.3
DISEASES OF THE EAR	10,665	5,228	5,457	5.5	5.6	5.4
HEADACHES	2,344	*	1,662	1.2	*	1.7
GENITOURINARY DISORDERS	17,198	3,324	13,874	8.9	3.6	13.8
DELIVERIES AND DISORDERS OF PREGNANCY AND THE PUERPERIUM	18,183	---	18,183	9.4	---	18.1
DISEASES OF THE SKIN	4,582	*	3,495	2.4	*	3.5
DISEASES OF THE MUSCULOSKELETAL SYSTEM	9,490	3,093	6,396	4.9	3.3	6.4
ALL OTHER ACUTE CONDITIONS	26,606	12,217	14,389	13.8	13.1	14.4

NOTE. N.o.s.—not otherwise specified; n.e.c.—not elsewhere classified.

TABLE 5. DAYS OF RESTRICTED ACTIVITY ASSOCIATED WITH ACUTE CONDITIONS AND DAYS OF RESTRICTED ACTIVITY PER 100 PERSONS PER YEAR, BY AGE, SEX, AND CONDITION GROUP: UNITED STATES, 1967

[Data are based on household interviews of the civilian, noninstitutional population. The survey design, general qualifications, and information on the reliability of the estimates are given in Appendix I. Definitions of terms are given in Appendix II]

SEX AND CONDITION GROUP	ALL AGES	UNDER 6	6-16	17-44	45 & OVER	ALL AGES	UNDER 6	6-16	17-44	45 & OVER
BOTH SEXES	DAYS OF RESTRICTED ACTIVITY IN THOUSANDS					DAYS OF RESTRICTED ACTIVITY PER 100 PERSONS PER YEAR				
ALL ACUTE CONDITIONS	1,455,088	204,915	319,372	499,405	431,396	752.4	874.3	731.1	726.7	749.9
INFECTIVE AND PARASITIC DISEASES	177,177	39,959	69,550	41,798	26,291	91.6	169.1	159.2	60.8	45.6
RESPIRATORY CONDITIONS	653,665	123,619	164,871	188,005	177,176	338.0	528.4	377.4	273.6	307.6
UPPER RESPIRATORY CONDITIONS	352,180	82,940	98,165	93,170	77,905	182.1	354.6	224.7	135.6	135.3
INFLUENZA	241,622	27,593	50,111	80,845	77,074	124.9	118.0	128.4	117.6	133.8
OTHER RESPIRATORY CONDITIONS	59,862	13,081	10,595	13,990	22,196	31.0	55.9	24.3	20.4	38.5
DIGESTIVE SYSTEM CONDITIONS	67,964	8,518	9,466	25,330	24,650	35.1	36.4	21.7	36.9	42.8
INJURIES	332,088	14,859	45,828	144,455	126,945	171.7	63.5	104.9	210.2	220.4
ALL OTHER ACUTE CONDITIONS	224,155	17,966	29,677	99,816	76,735	115.9	76.8	67.9	145.2	133.2
MALE										
ALL ACUTE CONDITIONS	638,154	109,567	161,744	195,481	171,362	684.6	919.8	730.5	603.8	641.0
INFECTIVE AND PARASITIC DISEASES	85,914	21,293	36,442	17,372	10,846	92.2	177.5	164.6	53.7	40.4
RESPIRATORY CONDITIONS	286,295	66,222	79,785	69,886	70,403	307.1	553.5	360.3	215.9	263.4
UPPER RESPIRATORY CONDITIONS	158,736	44,184	48,317	36,267	29,988	170.3	369.1	218.2	112.0	112.2
INFLUENZA	99,756	13,617	27,124	28,453	30,514	107.0	113.8	122.5	87.9	114.1
OTHER RESPIRATORY CONDITIONS	27,851	8,441	4,343	5,167	9,900	29.9	70.6	19.6	16.0	37.0
DIGESTIVE SYSTEM CONDITIONS	31,251	5,499	4,070	8,895	12,787	33.5	46.0	18.4	27.5	47.8
INJURIES	169,824	6,569	28,785	87,989	46,481	182.2	54.9	130.0	271.8	173.9
ALL OTHER ACUTE CONDITIONS	84,870	10,045	12,662	11,338	30,825	89.6	84.8	57.2	35.0	115.3
FEMALE										
ALL ACUTE CONDITIONS	816,934	94,948	157,628	303,924	260,434	815.4	830.8	731.6	836.0	843.8
INFECTIVE AND PARASITIC DISEASES	91,263	18,326	33,088	24,425	15,434	91.1	160.4	153.6	67.2	50.0
RESPIRATORY CONDITIONS	367,370	57,392	85,086	118,119	106,773	366.7	502.2	394.9	324.9	345.9
UPPER RESPIRATORY CONDITIONS	193,444	38,776	49,847	56,903	47,917	193.1	339.3	231.4	156.5	155.2
INFLUENZA	141,915	13,976	22,987	52,392	46,560	141.6	122.3	134.5	144.1	150.8
OTHER RESPIRATORY CONDITIONS	32,011	4,640	6,252	8,824	12,296	31.9	40.6	29.0	24.3	39.8
DIGESTIVE SYSTEM CONDITIONS	36,712	3,019	5,396	16,439	11,863	36.6	26.4	25.0	45.2	38.4
INJURIES	162,264	8,291	17,043	56,466	80,464	162.0	72.5	79.1	155.3	260.7
ALL OTHER ACUTE CONDITIONS	159,325	7,922	17,013	88,478	45,910	159.0	69.3	79.0	243.4	148.7

TABLE 8. DAYS OF BED DISABILITY ASSOCIATED WITH ACUTE CONDITIONS AND DAYS OF BED DISABILITY PER 100 PERSON PER YEAR, BY AGE, SEX, AND CONDITION GROUP: UNITED STATES, 1967

[Data are based on household interviews of the civilian, noninstitutional population. The survey design, general qualifications, and information on the reliability of the estimates are given in Appendix I. Definitions of terms are given in Appendix II]

SEX AND CONDITION GROUP	ALL AGES	UNDER 6	6-16	17-44	45 & OVER	ALL AGES	UNDER 6	6-16	17-44	45 & OVER
	DAYS OF BED DISABILITY IN THOUSANDS					DAYS OF BED DISABILITY PER 100 PERSONS PER YEAR				
BOTH SEXES										
ALL ACUTE CONDITIONS	611,150	84,030	144,765	213,375	168,989	316.0	359.2	331.4	310.5	293.4
INFECTIVE AND PARASITIC DISEASES	64,456	14,851	33,309	23,780	12,556	43.7	63.5	76.2	34.6	21.8
RESPIRATORY CONDITIONS	315,636	51,959	86,933	97,839	78,906	163.2	222.1	199.0	142.4	137.0
UPPER RESPIRATORY CONDITIONS	149,465	29,115	48,636	44,795	26,924	77.3	124.5	111.3	65.2	46.7
INFLUENZA	132,857	13,756	32,668	47,093	39,281	68.7	59.0	74.8	68.5	68.2
OTHER RESPIRATORY CONDITIONS	33,310	9,049	5,609	5,951	12,701	17.2	38.7	12.8	8.7	22.1
DIGESTIVE SYSTEM CONDITIONS	33,287	3,867	5,598	11,083	12,739	17.2	16.5	12.8	16.1	22.1
INJURIES	88,651	9,011	8,522	37,855	37,263	45.8	21.4	19.5	55.1	64.7
ALL OTHER ACUTE CONDITIONS	89,087	8,341	13,404	42,818	27,524	46.1	35.7	23.8	62.3	47.8
MALE										
ALL ACUTE CONDITIONS	266,635	44,824	70,175	79,842	69,795	283.9	374.7	316.9	246.4	261.1
INFECTIVE AND PARASITIC DISEASES	39,752	7,412	16,975	10,356	5,049	42.7	62.0	76.7	32.0	18.9
RESPIRATORY CONDITIONS	138,781	26,293	42,800	37,981	30,487	246.9	236.5	189.7	117.3	114.0
UPPER RESPIRATORY CONDITIONS	67,945	15,281	24,713	18,544	9,407	72.9	127.7	111.6	57.3	35.2
INFLUENZA	55,203	6,944	14,939	17,089	16,191	59.2	58.0	67.6	52.8	60.6
OTHER RESPIRATORY CONDITIONS	15,632	4,069	2,906	2,348	4,888	16.7	50.7	10.4	7.3	18.3
DIGESTIVE SYSTEM CONDITIONS	16,021	2,870	2,677	4,415	6,059	17.2	24.0	12.1	13.6	22.7
INJURIES	44,432	2,199	4,654	22,187	15,391	47.7	18.4	21.0	68.5	57.6
ALL OTHER ACUTE CONDITIONS	25,630	4,050	3,869	4,903	12,808	27.5	33.9	17.5	15.1	47.9
FEMALE										
ALL ACUTE CONDITIONS	344,523	39,206	74,590	133,533	99,194	345.9	343.1	346.2	367.3	321.4
INFECTIVE AND PARASITIC DISEASES	24,704	7,435	16,334	13,425	7,507	44.6	65.1	75.8	36.9	24.3
RESPIRATORY CONDITIONS	176,875	25,666	44,133	59,858	48,419	176.9	207.1	208.6	164.7	156.9
UPPER RESPIRATORY CONDITIONS	81,524	13,834	23,923	26,251	17,516	81.4	121.1	111.0	72.2	56.7
INFLUENZA	77,654	6,812	17,708	30,003	23,090	77.5	60.0	82.2	82.5	74.8
OTHER RESPIRATORY CONDITIONS	17,697	2,980	3,301	3,604	7,812	17.7	26.1	15.3	9.9	25.3
DIGESTIVE SYSTEM CONDITIONS	17,266	*	2,921	6,668	6,680	17.2	*	13.6	18.3	21.6
INJURIES	44,220	2,612	5,867	15,669	21,872	44.1	24.6	17.9	43.1	70.9
ALL OTHER ACUTE CONDITIONS	63,457	4,291	6,535	37,919	14,716	63.3	37.5	30.3	104.3	47.7

TABLE 8. DAYS LOST FROM WORK ASSOCIATED WITH ACUTE CONDITIONS AND DAYS LOST FROM WORK PER 100 CURRENTLY EMPLOYED PERSONS PER YEAR, BY AGE, SEX, AND CONDITION GROUP: UNITED STATES, 1967

[Data are based on household interviews of the civilian, noninstitutional population. The survey design, general qualifications, and information on the reliability of the estimates are given in Appendix I. Definitions of terms are given in Appendix II]

SEX AND CONDITION GROUP	ALL AGES-17 & OVER	17-44	45 & OVER	ALL AGES 17 & OVER	17-44	45 & OVER
	DAYS LOST FROM WORK IN THOUSANDS			DAYS LOST FROM WORK PER 100 CURRENTLY EMPLOYED PERSONS PER YEAR		
BOTH SEXES						
ALL ACUTE CONDITIONS	258,791	160,267	98,524	343.9	354.8	327.5
INFECTIVE AND PARASITIC DISEASES	20,957	14,658	6,299	27.8	32.4	20.9
RESPIRATORY CONDITIONS	102,740	58,575	44,165	136.5	129.7	146.8
UPPER RESPIRATORY CONDITIONS	46,189	28,535	17,655	61.4	63.2	58.7
INFLUENZA	47,013	26,777	20,236	62.5	59.3	67.3
OTHER RESPIRATORY CONDITIONS	9,538	3,264	6,274	12.7	7.2	20.9
DIGESTIVE SYSTEM CONDITIONS	13,385	7,801	5,585	17.8	17.3	18.6
INJURIES	83,706	55,630	28,076	111.2	123.1	93.3
ALL OTHER ACUTE CONDITIONS	38,003	23,604	14,398	50.5	52.3	47.9
MALE						
ALL ACUTE CONDITIONS	156,602	99,911	62,692	326.6	329.4	327.4
INFECTIVE AND PARASITIC DISEASES	14,035	9,506	4,529	29.5	33.3	23.7
RESPIRATORY CONDITIONS	61,905	33,586	28,319	129.9	117.8	147.9
UPPER RESPIRATORY CONDITIONS	26,567	16,144	10,422	55.7	56.6	54.4
INFLUENZA	29,231	15,450	13,782	61.3	54.2	72.2
OTHER RESPIRATORY CONDITIONS	6,106	2,042	4,065	12.8	7.2	21.2
DIGESTIVE SYSTEM CONDITIONS	8,388	3,564	4,824	17.6	12.5	25.2
INJURIES	56,676	40,830	15,846	118.9	143.2	82.8
ALL OTHER ACUTE CONDITIONS	15,598	6,426	9,172	32.7	22.5	47.9
FEMALE						
ALL ACUTE CONDITIONS	102,189	60,357	35,832	370.2	398.1	327.8
INFECTIVE AND PARASITIC DISEASES	6,922	5,152	1,770	25.1	30.5	16.2
RESPIRATORY CONDITIONS	40,835	24,989	15,846	147.9	149.9	145.0
UPPER RESPIRATORY CONDITIONS	19,622	12,390	7,232	71.1	74.3	66.2
INFLUENZA	17,781	11,327	6,454	64.4	68.3	58.6
OTHER RESPIRATORY CONDITIONS	3,432	*	2,210	12.4	*	20.2
DIGESTIVE SYSTEM CONDITIONS	4,997	4,237	*	18.1	25.4	*
INJURIES	27,030	14,799	12,231	97.9	88.8	111.9
ALL OTHER ACUTE CONDITIONS	22,404	17,179	5,226	81.2	103.1	47.8

Table 9. Number and percent distribution of persons with limitation of activity due to chronic conditions, by degree of limitation according to sex and age: United States, 1967

[Data are based on household interviews of the civilian noninstitutional population. The survey design, general qualifications, and information on the reliability of the estimates are given in Appendix I. Definitions of terms are given in Appendix II]

Sex and age	Total population	With activity limitation	With limitation in major activity[1]	With no activity limitation	Total population	With activity limitation	With limitation in major activity[1]	With no activity limitation
	Number in thousands				Percent distribution			
Both sexes								
All ages	193,403	22,248	16,805	171,155	100.0	11.5	8.7	88.5
Under 17 years	67,078	1,418	712	65,660	100.0	2.1	1.1	97.9
17-44 years	68,726	4,994	3,245	63,732	100.0	7.3	4.7	92.7
45-64 years	39,370	7,493	5,637	32,077	100.0	18.9	14.2	81.1
65+ years	18,229	8,343	7,212	9,885	100.0	46.3	40.0	53.7
Male								
All ages	93,212	11,372	9,098	81,839	100.0	12.2	9.8	87.8
Under 17 years	34,106	789	384	33,316	100.0	2.3	1.1	97.7
17-44 years	32,373	2,537	1,787	29,837	100.0	7.8	5.5	92.2
45-64 years	18,924	3,894	3,113	15,030	100.0	20.6	16.5	79.4
65+ years	7,809	4,153	3,814	3,656	100.0	53.2	48.8	46.8
Female								
All ages	100,191	10,876	7,707	89,315	100.0	10.9	7.7	89.1
Under 17 years	32,972	629	328	32,343	100.0	1.9	1.0	98.1
17-44 years	36,353	2,457	1,458	33,896	100.0	6.8	4.0	93.2
45-64 years	20,447	3,599	2,523	17,047	100.0	17.4	12.2	82.6
65+ years	10,219	4,190	3,398	6,029	100.0	41.0	33.3	59.0

[1]Major activity refers to ability to work, keep house, or engage in school or preschool activities.

NOTE: For official population estimates for more general use, see Bureau of the Census reports on the civilian population of the United States, in Current Population Reports: Series P-20, P-25, and P-60.

Table 10. Number of persons injured and number of persons injured per 100 persons per year, by class of accident, sex, and age: United States, 1967

[Data are based on household interviews of the civilian noninstitutional population. The survey design, general qualifications, and information on the reliability of the estimates are given in Appendix I. Definitions of terms are given in Appendix II]

Sex and age	Total	Class of accident				
		Moving motor vehicle		While at work	Home	Other
		Total	Traffic			
	Number of persons injured in thousands					
Both sexes						
All ages	52,967	3,780	3,628	9,203	23,012	18,607
Under 6 years	8,852	*	*	...	6,068	2,557
6-16 years	12,863	*	*	...	5,117	7,514
17-44 years	19,832	2,427	2,355	5,971	6,792	5,554
45-64 years	8,610	*	*	3,006	3,125	2,436
65 years and over	2,810	*	*	*	1,929	*
Male						
All ages	30,465	1,578	1,545	8,032	10,378	11,772
Under 6 years	5,229	*	*	...	3,509	1,581
6-16 years	8,283	*	*	...	2,890	5,330
17-44 years	11,494	1,085	1,085	5,477	2,627	3,352
45-64 years	4,338	*	*	2,368	909	1,213
65 years and over	1,121	*	*	*	*	*
Female						
All ages	22,502	2,202	2,084	1,171	12,633	6,835
Under 6 years	3,623	*	*	...	2,560	977
6-16 years	4,580	*	*	...	2,227	2,184
17-44 years	8,339	1,342	1,269	*	4,166	3,201
45-64 years	4,272	*	*	*	2,216	1,323
65 years and over	1,689	*	*	*	1,284	*
	Number of persons injured per 100 persons per year					
Both sexes						
All ages	27.4	2.0	1.9	4.8	11.9	9.6
Under 6 years	37.8	*	*	...	25.9	10.9
6-16 years	29.4	*	*	...	11.7	17.2
17-44 years	28.9	3.5	3.4	8.7	9.9	8.1
45-64 years	21.8	*	*	7.6	7.9	6.2
65 years and over	15.6	*	*	*	10.7	*
Male						
All ages	32.7	1.7	1.7	8.6	11.1	12.6
Under 6 years	43.7	*	*	...	29.3	13.2
6-16 years	37.4	*	*	...	13.1	24.1
17-44 years	35.5	3.4	3.4	16.9	7.5	10.4
45-64 years	22.9	*	*	12.5	4.8	6.4
65 years and over	14.4	*	*	*	*	*
Female						
All ages	22.5	2.2	2.1	1.2	12.6	6.8
Under 6 years	31.7	*	*	...	22.2	8.5
6-16 years	21.3	*	*	...	10.3	10.1
17-44 years	22.9	3.7	3.5	*	12.0	9.1
45-64 years	20.7	*	*	*	10.7	5.9
65 years and over	16.5	*	*	*	12.6	*

NOTE: Excluded from these statistics are all conditions involving neither restricted activity nor medical attention. The sum of data for the four classes of accidents may be greater than the total because the classes are not mutually exclusive.

Table 11. Days of restricted activity associated with injury' and days of restricted activity per 100 persons per year, by class of accident, sex, and age: United States, 1967

[Data are based on household interviews of the civilian noninstitutional population. The survey design, general qualifications, and information on the reliability of the estimates are given in Appendix I. Definitions of terms are given in Appendix II]

Sex and age	Total	Class of accident				
		Moving motor vehicle		While at work	Home	Other
		Total	Traffic			
	Days of restricted activity in thousands					
Both sexes						
All ages	552,118	120,118	112,953	143,389	169,583	150,724
Under 6 years	12,864	2,741	2,176	...	6,167	4,521
6-16 years	49,511	4,635	4,551	...	16,098	28,750
17-44 years	213,571	61,734	59,180	72,265	44,694	50,218
45-64 years	166,040	33,501	31,072	58,393	48,825	35,927
65 years and over	110,132	17,488	15,975	12,731	53,801	31,300
Male						
All ages	281,524	55,065	52,092	118,241	44,942	87,021
Under 6 years	6,569	*	*	...	3,074	3,359
6-16 years	31,777	2,956	2,853	...	9,818	19,003
17-44 years	123,458	30,984	29,992	61,210	11,837	32,106
45-64 years	82,753	11,957	11,228	45,947	9,469	22,067
65 years and over	36,964	9,032	7,884	11,084	10,744	10,485
Female						
All ages	270,594	65,053	60,862	25,148	124,642	63,703
Under 6 years	6,298	2,606	2,061	...	3,093	*
6-16 years	17,733	1,699	1,699	...	6,279	9,755
17-44 years	90,113	30,748	29,188	11,055	32,858	18,112
45-64 years	83,284	21,544	19,844	12,445	39,355	13,860
65 years and over	73,168	8,434	8,091	1,448	43,057	20,814
	Days of restricted activity per 100 persons per year					
Both sexes						
All ages	285.5	62.1	58.4	74.1	87.7	77.9
Under 6 years	55.0	11.7	9.3	...	26.4	19.3
6-16 years	113.3	10.7	10.4	...	36.8	65.8
17-44 years	310.8	89.8	86.1	105.1	65.0	73.1
45-64 years	419.6	84.7	78.5	147.6	123.4	90.8
65 years and over	610.9	97.0	88.6	70.6	298.4	173.6
Male						
All ages	302.0	59.1	55.9	126.9	48.2	93.4
Under 6 years	54.9	*	*	...	25.7	28.1
6-16 years	143.5	13.4	12.9	...	44.3	85.8
17-44 years	381.4	95.7	92.6	189.1	36.6	99.2
45-64 years	437.3	63.2	59.3	242.8	50.0	116.6
65 years and over	473.4	115.7	101.0	141.9	137.6	134.3
Female						
All ages	270.1	64.9	60.7	25.1	124.4	63.6
Under 6 years	55.1	22.8	17.9	...	27.1	*
6-16 years	82.3	7.9	7.9	...	29.1	45.3
17-44 years	247.9	84.6	80.3	30.4	90.4	49.8
45-64 years	403.4	104.3	96.1	60.3	190.6	67.1
65 years and over	716.0	82.7	79.2	14.1	421.3	203.7

[1]Includes disability days associated with current injuries and impairments due to injury.

NOTE: The sum of data for the four classes of accidents may be greater than the total because the classes are not mutually exclusive.

Table 12. Days of bed disability associated with injury' and days of bed disability per 100 persons per year, by class of accident, sex, and age: United States, 1967

[Data are based on household interviews of the civilian noninstitutional population. The survey design, general qualifications, and information on the reliability of the estimates are given in Appendix I. Definitions of terms are given in Appendix II]

Sex and age	Total	Class of accident				
		Moving motor vehicle		While at work	Home	Other
		Total	Traffic			
	Days of bed disability in thousands					
Both sexes						
All ages	140,135	33,834	32,448	33,943	40,378	40,046
Under 6 years	4,239	*	*	...	1,924	1,767
6-16 years	8,943	1,375	*	...	2,116	5,252
17-44 years	54,244	15,680	15,302	19,980	9,830	12,188
45-64 years	41,548	9,854	9,744	12,654	11,143	11,589
65 years and over	31,162	5,612	5,384	*	13,365	9,250
Male						
All ages	69,597	13,458	13,355	27,272	9,723	23,562
Under 6 years	2,199	*	*	...	*	1,520
6-16 years	5,125	*	*	...	*	3,441
17-44 years	30,302	6,214	6,214	16,613	2,087	8,281
45-64 years	19,717	3,626	3,626	9,351	*	7,074
65 years and over	12,054	2,977	2,977	*	4,868	3,244
Female						
All ages	70,538	20,376	19,094	6,671	30,655	16,484
Under 6 years	2,039	*	*	...	*	*
6-16 years	3,818	*	*	...	*	1,811
17-44 years	23,741	9,466	9,088	3,368	7,743	3,906
45-64 years	21,832	6,228	6,118	3,303	9,898	4,515
65 years and over	19,108	2,635	2,407	*	10,697	6,004
	Days of bed disability per 100 persons per year					
Both sexes						
All ages	72.5	17.5	16.8	17.6	20.9	20.7
Under 6 years	18.1	*	*	...	8.2	7.6
6-16 years	20.5	3.6	*	...	4.8	12.0
17-44 years	78.9	22.8	22.3	29.1	14.3	17.7
45-64 years	105.0	24.9	24.6	32.0	28.2	29.3
65 years and over	172.8	31.1	29.9	*	83.2	51.3
Male						
All ages	74.7	14.4	14.3	29.3	10.4	25.3
Under 6 years	18.4	*	*	...	*	12.7
6-16 years	23.1	*	*	...	*	15.5
17-44 years	94.2	19.2	19.2	51.3	6.4	25.6
45-64 years	104.2	19.2	19.2	49.4	*	37.4
65 years and over	134.4	38.1	38.1	*	59.8	41.6
Female						
All ages	70.4	20.3	19.1	6.7	30.6	16.5
Under 6 years	17.8	*	*	...	*	*
6-16 years	17.7	*	*	...	*	8.4
17-44 years	65.3	26.0	25.0	9.3	21.3	10.7
45-64 years	105.7	30.2	29.6	16.0	47.9	21.9
65 years and over	187.0	25.8	23.6	*	104.7	58.8

[1]Includes disability days associated with current injuries and impairments due to injury.

NOTE: The sum of data for the four classes of accidents may be greater than the total because the classes are not mutually exclusive.

TABLE 13. NUMBER OF DISCHARGES FROM SHORT-STAY HOSPITALS, NUMBER OF DISCHARGES PER 100 PERSONS PER YEAR, NUMBER OF HOSPITAL DAYS, AND AVERAGE LENGTH OF STAY, BY SEX AND AGE: UNITED STATES, BASED ON DATA COLLECTED IN HEALTH INTERVIEWS IN 1967

[Data are based on household interviews of the civilian, noninstitutional population. The survey design, general qualifications, and information on the reliability of the estimates are given in Appendix I. Definitions of terms are given in Appendix II]

AGE	BOTH SEXES	MALE	FEMALE	BOTH SEXES	MALE	FEMALE
	NUMBER OF DISCHARGES IN THOUSANDS			NUMBER OF DISCHARGES PER 100 PERSONS PER YEAR		
ALL AGES	23,756	9,479	14,278	12.3	10.2	14.3
UNDER 17 YEARS	4,345	2,460	1,888	6.5	7.2	5.7
17-24 YEARS	3,811	832	2,978	16.3	7.8	23.6
25-34 YEARS	3,455	791	2,665	15.7	7.5	23.0
35-44 YEARS	2,984	1,127	1,856	12.8	10.1	15.3
45-64 YEARS	5,614	2,596	3,018	14.2	13.7	14.6
65 & OVER YEARS	3,543	1,670	1,873	19.7	21.4	18.3
	NUMBER OF HOSPITAL DAYS IN THOUSANDS			AVERAGE LENGTH OF STAY		
ALL AGES	201,881	96,981	104,899	8.5	10.2	7.3
UNDER 17 YEARS	23,075	13,000	10,075	5.5	5.6	5.3
17-24 YEARS	26,769	7,849	18,144	7.5	9.2	6.4
25-34 YEARS	27,632	9,246	18,686	8.1	8.6	9.9
35-44 YEARS	25,039	12,702	12,937	8.6	11.3	7.0
45-64 YEARS	82,759	34,294	28,465	11.2	13.2	9.4
65 & OVER YEARS	47,612	23,290	24,572	13.5	13.9	13.1

NOTE: These statistics are based on data collected in health interviews. They will differ from those reported by the Hospital Discharge Survey because of differences in population covered and types of hospitals included.

Table 14. Population, number, and percent distribution of persons with short-stay hospital episodes, by number of episodes according to sex and age: United States, based on data collected in health interviews in 1967

[Data are based on household interviews of the civilian, noninstitutional population. The survey design, general qualifications, and information on the reliability of the estimates are given in Appendix I. Definitions of terms are given in Appendix II]

Sex and age	Population	Number of hospital episodes				Population	Number of hospital episodes			
		None	1	2	3+		None	1	2	3+
Both sexes	Number of persons in thousands					Percent distribution				
All ages	193,403	174,458	16,184	2,174	586	100.0	90.2	8.4	1.1	0.3
Under 17 years	67,078	63,524	3,191	300	63	100.0	94.7	4.8	0.4	0.1
17-24 years	23,344	20,216	2,762	308	58	100.0	86.6	11.8	1.3	0.2
25-34 years	22,062	19,057	2,622	310	73	100.0	86.4	11.9	1.4	0.3
35-44 years	23,319	20,880	2,062	289	88	100.0	89.5	8.8	1.2	0.4
45-64 years	39,570	35,334	3,485	577	175	100.0	89.3	8.8	1.5	0.4
65+ years	18,029	15,447	2,062	390	129	100.0	85.7	11.4	2.2	0.7
Male										
All ages	93,212	85,854	6,216	885	257	100.0	92.1	6.7	0.9	0.3
Under 17 years	34,106	32,108	1,788	170	*	100.0	94.1	5.2	0.5	*
17-24 years	10,712	10,031	598	70	*	100.0	93.6	5.6	0.7	*
25-34 years	10,498	9,871	534	82	*	100.0	94.0	5.1	0.8	*
35-44 years	11,163	10,281	725	115	*	100.0	92.1	6.5	1.0	*
45-64 years	18,924	16,954	1,639	240	90	100.0	89.6	8.7	1.3	0.5
65+ years	7,809	6,609	932	208	61	100.0	84.6	11.9	2.7	0.8
Female										
All ages	100,191	88,604	9,968	1,290	329	100.0	88.4	9.9	1.3	0.3
Under 17 years	32,972	31,416	1,403	130	*	100.0	95.3	4.3	0.4	*
17-24 years	12,632	10,184	2,164	238	*	100.0	80.6	17.1	1.9	*
25-34 years	11,565	9,186	2,089	329	61	100.0	79.4	18.1	2.8	0.5
35-44 years	12,156	10,600	1,337	174	*	100.0	87.2	11.0	1.4	*
45-64 years	20,647	18,380	1,845	336	85	100.0	89.0	8.9	1.6	0.4
65+ years	10,219	8,838	1,131	182	68	100.0	86.5	11.1	1.8	0.7

NOTE: For official population estimates for more general use, see Bureau of the Census reports on the civilian population of the United States, in Current Population Reports: Series P-20, P-25, and P-60.

Table 15. Number of short-stay hospital days and number of days per person with 1+ episodes, by number of episodes, sex, and age: United States, based on data collected in health interviews in 1967

[Data are based on household interviews of the civilian, noninstitutional population. The survey design, general qualifications, and information on the reliability of the estimates are given in Appendix I. Definitions of terms are given in Appendix II]

Sex and age	Number of hospital episodes							
	All episodes	1	2	3+	All episodes	1	2	3+
	Hospital days in thousands				Days per person with episodes			
Both sexes								
All ages	186,937	124,235	42,039	20,663	9.9	7.7	19.3	35.3
Under 17 years	22,524	16,725	4,159	1,641	6.3	5.2	13.9	26.0
17-24 years	19,041	13,992	3,978	1,072	6.1	5.1	12.9	18.5
25-34 years	20,887	14,393	4,268	2,227	7.0	5.5	13.8	30.5
35-44 years	24,869	16,156	5,977	2,736	10.2	7.8	20.7	31.1
45-64 years	56,003	36,473	12,664	6,866	13.2	10.5	21.9	39.2
65+ years	43,612	26,497	10,993	6,122	16.9	12.9	28.2	47.5
Male								
All ages	88,555	56,909	20,984	10,663	12.0	9.2	23.7	41.5
Under 17 years	13,049	9,364	2,674	1,011	6.5	5.2	15.7	*
17-24 years	6,317	4,483	1,543	291	9.3	7.5	22.0	*
25-34 years	5,642	3,724	1,377	540	9.0	7.0	16.8	*
35-44 years	11,900	7,149	3,238	1,512	13.5	9.9	28.2	*
45-64 years	29,999	19,878	5,979	4,143	15.2	12.1	24.9	46.0
65+ years	21,648	12,310	6,172	3,165	18.0	13.2	29.7	51.9
Female								
All ages	98,382	67,327	21,055	10,000	8.5	6.8	16.3	30.4
Under 17 years	9,475	7,361	1,485	629	6.1	5.2	11.4	*
17-24 years	12,724	9,508	2,435	780	5.2	4.4	10.2	*
25-34 years	15,246	10,669	2,890	1,687	6.4	5.1	12.6	27.7
35-44 years	12,968	9,006	2,739	1,223	8.3	6.7	15.7	*
45-64 years	26,004	16,596	6,685	2,724	11.5	9.0	19.9	32.0
65+ years	21,965	14,187	4,821	2,956	15.9	12.5	26.3	43.5

TABLE 16. DAYS OF DISABILITY AND DAYS OF DISABILITY PER PERSON PER YEAR, BY SEX AND AGE: UNITED STATES, 1967

[Data are based on household interviews of the civilian, noninstitutional population. The survey design, general qualifications, and information on the reliability of the estimates are given in Appendix I. Definitions of terms are given in Appendix II]

SEX AND AGE	RESTRICTED-ACTIVITY DAYS	BED-DISABILITY DAYS	WORK-LOSS DAYS[1]
	DAYS OF DISABILITY IN THOUSANDS		
BOTH SEXES			
ALL AGES	2,953,202	1,109,428	406,005
UNDER 17 YEARS	617,567	270,892	...
17-24 YEARS	231,201	100,551	59,142
25-44 YEARS	627,374	232,125	154,522
45-64 YEARS	831,531	282,447	170,043
65 & OVER YEARS	645,529	223,413	22,298
MALE			
ALL AGES	1,296,362	464,461	251,652
UNDER 17 YEARS	322,351	135,529	...
17-24 YEARS	89,337	35,396	30,937
25-44 YEARS	238,338	85,939	92,199
45-64 YEARS	390,735	126,285	113,303
65 & OVER YEARS	257,600	81,309	15,213
FEMALE			
ALL AGES	1,656,840	644,967	154,353
UNDER 17 YEARS	295,215	135,363	...
17-24 YEARS	141,864	65,151	28,205
25-44 YEARS	391,036	146,186	62,323
45-64 YEARS	440,796	156,163	58,740
65 & OVER YEARS	387,929	142,104	7,085
	DAYS OF DISABILITY PER PERSON PER YEAR		
BOTH SEXES			
ALL AGES	15.3	5.7	5.4
UNDER 17 YEARS	9.2	4.0	...
17-24 YEARS	9.9	4.3	4.2
25-44 YEARS	13.8	5.1	5.[illegible]
45-64 YEARS	21.[illegible]	[illegible].1	[illegible].6
65 & OVER YEARS	35.8	12.4	8.7
MALE			
ALL AGES	13.9	5.0	5.3
UNDER 17 YEARS	9.5	4.0	...
17-24 YEARS	8.3	3.3	4.0
25-44 YEARS	10.9	4.0	4.5
45-64 YEARS	20.6	6.7	6.7
65 & OVER YEARS	33.0	10.4	6.9
FEMALE			
ALL AGES	16.5	6.4	5.6
UNDER 17 YEARS	9.0	4.1	...
17-24 YEARS	11.2	5.2	4.6
25-44 YEARS	16.5	6.2	5.9
45-64 YEARS	21.3	7.6	5.8
65 & OVER YEARS	38.0	13.9	6.4

[1]Work loss reported for currently employed persons aged 17 years and over.

PLAINTIFFS' EXHIBIT NO. 88A
Statement of Dr. Andre Hellergers, filed on December 1, 1971 with the FCC, Docket No. 19413, in the matter of Petitions filed by the EEOC

BEFORE THE
FEDERAL COMMUNICATION COMMISSION
WASHINGTON, D.C. 20544

In the Matter of:

Petitions filed by the
EQUAL EMPLOYMENT OPPORTUNITY
COMMISSION, et al.

DOCKET NO. 19143

STATEMENT OF ANDRE E. HELLEGERS FILED WITH FEDERAL COMMUNICATION COMMISSION ON DECEMBER 1, 1971

My name is Andre E. Hellegers. I am presently Professor of Obstetrics-Gynecology, Professor of Physiology-Biophysics as well as the Director of Population Research at Georgetown University. In addition I am currently president of the Perinatal Research Society. A listing of my further qualifications can be found in the complete curriculum vita attached hereto.

There are to my knowledge no physiological data which warrant a rule that women in pregnancies should cease working. It should be recognized that if a woman were to develop diabetes, hypertension, or certain other conditions in pregnancy, then it would be possible that a stoppage of work would become necessary, but this in no way differentiates pregnancy from nonpregnancy, since this statement would be equally true for nonpregnant

women, or indeed for men. No medical evidence can be adduced for the need to cease working in pregnancy. Indeed this may be deleterious in some circumstances in which:

1. Loss of income would occur, which might decrease the quality of the diet consumed in pregnancy.
2. A woman has several children, in which case her house work is likely to put more strain on her than a regular job in the labor force.
3. The psychological stress of doing nothing could be worse than that of being gainfully employed.

The Georgetown Obstetrical Service's advice regarding the desireability of working in pregnancy is individualized for every patient as it would be for non-pregnant patients, male or female, who ask whether they are capable of doing a particular job.

It is of some significance that women doctors and nurses, who are working on the obstetrical and other services at the hospital often continue working right up to the day of delivery. This of course would not be so if the medical profession thought that working in pregnancy was contra-indicated.

Finally, in the only large-scale analysis of work in pregnancy, involving close to four million women, women without incomes had a poorer outcome of pregnancy than women with incomes. The positive correlation between higher social classes and incomes with better pregnancy outcome, and lower social classes and income with worse pregnancy outcome is of course well known.

Knowingly, and in the absence of disease, to remove the opportunity for the income-producing activity from women is therefore to expose women and their unborn children to unnecessary reproductive stresses, unless financial compensation is given.

PLAINTIFFS' EXHIBIT NO. 88B
Testimony of Dr. Andre E. Hellegers on February 14, 1972 before the Federal Communications Commission, Docket No. 19143, in the Matter of Petitions filed by the EEOC.

BEFORE THE
FEDERAL COMMUNICATION COMMISSION
WASHINGTON, D.C. 20554

In the Matter of:

Petitions filed by the
EQUAL EMPLOYMENT OPPORTUNITY
COMMISSION, et al.

DOCKET NO. 19143

TESTIMONY OF DR. ANDRE E. HELLEGERS

PRESIDING EXAMINER: The hearing will be in order.
MR. COPUS: I would like to have a document which is entitled "Testimony of Dr. Andre E. Hellegers marked as EEOC 13.

I have given two copies to the Reporter and copies have been previously distributed to all the parties.
PRESIDING EXAMINER: It will be so identified.
(The document referred to was marked EEOC Exhibit No. 13 for identification.)

Whereupon, ANDRE E. HELLEGERS was called as a witness and, after being first duly sworn, was examined and testified as follows:

DIRECT EXAMINATION

BY MR. COPUS:

Q. Would you state your name, please? A. Andre E. Hellegers.

Q. What is your business address? A. 3800 Reservoir Road, Georgetown University Hospital.

Q. What do you do there? A. I am Professor of Obstetrics and Gynecology.

Q. Do you have before you a document entitled "Testimony of Andre E. Hellegers"? A. I do.

Q. Did you prepare that document or was it prepared under your direction? A. I prepared it.

Q. Do you have any changes or corrections to make at this time? A. No, I don't.

Q. Do you, then, adopt this testimony as your own testimony and is it true and correct to the best of your information, knowledge and belief? A. That is correct.
MR. COPUS: I now offer Dr. Hellegers for Voir Dire and Cross-Examination.

VOIR DIRE EXAMINATION

BY MR. LEVY:

Q. Dr. Hellegers, is your present position as stated in the curriculum vita just identified?
What type of work does this – are you involved in?
A. I ought to explain what the setup is at Georgetown. There was created, as you may have read in the paper, the Kennedy Institute for Population Studies. It has three subdivisions, one center for population research which does demography and sociology One is a division of bioethics which deals with ethics in medicine and one is a division of reproductive biology which deals with genetics, fetal physiology and so forth. That, incidentally, happened after this testimony was prepared.

Q. Do you direct all three of those divisions?
A. Yes, I am Director of the Institute and each sub-center has a head of its own.

Q. Does this research include analysis of differences in perinatal mortality, prematurity, child spacing, all kinds of problems like that? A. It does not deal fundamentally – intellectual differences between the races?

Q. Your reference is to infant mortality? A. Yes, fetal mortality.

* * *

Q. Is it concentrated essentially on the infant or fetal level, Doctor, rather than the adult or late childhood level? A. Yes, I would say what are the various the biological interests to which your research is directed? in the quality of reproduction, firstly.

Q. Your curriculum vita also indicates that you are a past President of a Perinantal Research Society.
A. That is correct.

Q. Can you tell us what is perinatal research?
A. Perinatal research is that research which deals with the perinatal period, around birth, namely before and after, so the society is composed of three groups of Professions–obstetricians who are mainly interested in the fetus; pediatricians, who are mainly interested in the newborn, and neonatology and basic scientists who are interested in embryology and the development of the fetus, and so on.

* * *

CROSS-EXAMINATION

BY MR. LEVY:

Q. At pages one and two of your testimony, you mention diabetes, hypertension or certain other conditions in pregnancy as making it possible that a work stoppage would become necessary. Wouldn't such conditions as diabetes and hypertension make it probable if not mandatory to stop work? A. It would depend on how you would define the diabetes and the hypertension. There are a lot of non-pregnant men and women with diabetes and hypertension working. That in itself is not a contra-indication to work. If it were, I think a lot of executives would be out of jobs.

PRESIDING EXAMINER: How about lawyers.

THE WITNESS: Yes, and doctors.

BY MR. LEVY:

Q. Can you identify for us the certain other conditions to which you refer in that sentence? A. Congenital heart disease, heart failure, cancer, any kind of thing that would make anybody stop working. Let me put it that way.

PRESIDING EXAMINER: Are those types that would be aggravated by a pregnancy?

THE WITNESS: No, not necessarily. I am sorry, I did not have in mind a particular aggravation by pregnancy. I had in mind there are obviously pregnant women who should not work as obviously there are men who should not work.

BY MR. LEVY:

Q. Dr. Hellegers, at page two, you seem to state categorically that there is no medical evidence for the need

to cease working in pregnancy on the one hand and Services policy of being individualized for every patient. Are these two statements not inconsistent? A. No, I don't think so. Perhaps I can explain it a little lower down, even. One has to individualize in every man and in every woman who comes to consult you, whether they should or should not work. What I am trying to say here is there is nothing inherent in the pregnant state that prevent some from working and the individualization simply means I would say to someone with a massive brain tumor who cannot see straight they might be better off not driving a car. That is what I meant by individualization.

Q. What are the bases on which the Georgetown Obstetrical Services make an individualized determination whether a patient is capable of doing a job?
A. I would say if a patient has hypertension which is out of control, if a person has diabetes which is out of control, and requires administration to a hospital and administration of insulin, then obviously, you would admit her to a hospital. You would do the same thing for a man.

Q. Does pregnancy commonly put stress on such organs as the kidney and the liver? A. No, it doesn't; I think it is more by virtue of weight and not by virtue of pregnancy. It is akin to an obesity situation.

Q. Couldn't continuation at a job involve exposure to toxic substances which would produce no harm to a normal non-pregnant woman prove to be harmful to a pregnant woman? A. It is an interesting question. My answer to that would be factually yes, providing that the exposure be in the first 12 weeks of pregnancy which is

namely when the organs are being formed. The difficulty with obstetrical practice is that we have yet to see patients after the time for the damage of irradiation in chemicals has gone by. It is an embryological problem that arises in the first 12 weeks.

Q. I was asking that question as to harm to the pregnant woman herself rather than the fetus she was carrying. A. I don't think that pregnancy increases the harm which a noxious agent can do to a woman. Let me put it that way.

Q. But you would say that continuation of jobs involving potential exposure to various kinds of radiation or toxic matters or ultra-sound could be potentially harmful to the fetus? A. Ultra-sound I would not go along with because as you know, we use it as a major tool in obstetrics diagnosis. I certainly don't think anybody should be exposed in pregnancy to irradiation for several reasons. One, I don't think anybody should be exposed to irradiation, period. That would be number one. The second problem, obviously, is the fetus in utero would have developing gonads and you would certainly not like to see developing gonads exposed to irradiation any more than I would like to see my gonads exposed to radiation. From that standpoint, you are best to be beyond the reproductive age.

Q. Can't continuation of certain jobs involving physical agility, stamina or dexterity, and by that I mean, for example, jobs which would involve truck driving, climbing poles or ladders, bending, lifting, squatting, working in confined manholes—can't such jobs and the continuation in such jobs tend to increase the risk of accident as pregnancy progresses?

A. Yes, I imagine that it would be very difficult to fit a 9-months pregnancy between you and the steering wheel of a truck. I think common sense would say it is a problem of a 25 weight if you would like being interposed between you and a telephone pole.

Q. I was not asking so much, Doctor, about discomfort or inconvenience or crowding as I was about the likelihood of jobs which involve such physical stresses increasing the risk of accident to the person as pregnancy progresses. Not by virtue of the pregnant state; by virtue of the mass, yes, indeed. You cannot get away from the fact that you are carrying a 25-pound pack on the front of your abdomen. There is obviously a logistic problem having a 25-pound weight sitting in front of one's abdoman. I would think this would be also for a gastric tumor, if you like, anything that represents a weight interposed between you and another object. It is there. Common sense would say that.

Q. Particularly in pregnancy, such weight can tend to lessen agility, speed of reaction, speed of movement, can it not, Doctor? A. I would say that that is true for anybody with a 20-pound weight on his stomach.

Q. When you make your individualized determination of capability to continue in a job, do you do so only from the point of view of the patient's health, but from the point of view of the employer's interest in efficient and satisfactory job performance as well? A. Obviously, as a physician, you do it from the point of view of the patient's health. You would find what kind of position the patient was in and then make a determination whether it was reasonable. You mentioned a moment ago going down a manhole. I have a suspicion I would ask my

patient how big is the manhole before I individualized her to squeeze through or not squeeze through. It is largely determined by common sense.

Q. Can't factors associated with normal pregnancy such as increased fluid retention, nausea, swollen ankles, bladder pressure, generally lessen agility because of this 25-pound weight?Can't some or all of these result in serious diminution in the speed and efficiency required for the performance of certain jobs? A. Let me put it this way: The water retention in pregnancy is amniotic fluid is 1000 CCs which would be two pounds of water sitting there and then by and large something like five pounds of water which is excess retained in pregnancy and excreted afterwards, so we are talking about something like seven pounds of water which is a heck of a sight less than is carried by most obese men. I cannot ascribe it to pregnancy but I can ascribe seven pounds of water retained in pregnancy. I cannot ascribe any differences then from men who have had nephritis, to beer drinkers, whatever else retains water, or even salt eaters. If someone has a particular predilection for salt, they are going to stash away a few pounds of water.

Q. What about some of the other factors that I mentioned?Is morning sickness or nausea fairly common or at least not uncommon in the first trimester of pregnancy? A. That is correct, yes.

Q. Could that result in diminution of the efficiency required for the satisfactory performance of certain jobs? A. Yes, I would think it would be in the same ball park as men with ulcers, burping, nausea. Understand me, I am in favor of good health. My testimony was not directed to whether there aren't changes in a woman's

body in pregnancy. Obviously there are. My testimony was directed to the question of work.

Q. I am just trying to explore certain parameters of your views. What about bladder pressure?Is it not uncommon for the developing fetus to impose greater pressure on the bladder than in the normal non-pregnant state? A. Yes, it does but women, by and large, void less than men. If voiding in frequency and quantity of urine becomes an issue, then people would say men are in more trouble than women because they void more. That is if terms of CCs of urine produced per day is more than women. I cannot ascribe that to a disease.

Q. If there were a job that required continued attendance at a station for let us say hour-long intervals and a normally pregnant woman could not sustain the bladder pressure for that long. This could interfere, could it not, with the efficiency of that operation?
A. Yes, if you have to go to the john, you have to go to the john, man, woman, pregnant woman or anyone else. I must agree.

Q. Again, Doctor, are swelling of the ankles fairly common in pregnancy? A. Yes, it is.

Q. Can that not possibly have an effect on the satisfactory performance of certain jobs which would call for speed of movement, locomotion? A. It is impossible to answer that.

Q. You are using void in a different sense.
A. Yes. It is a kind of theoretical statement which asks are our ankles which are four inches in circumference any better than ankles which are six inches in circumference. It is an impossible question for me to answer. I don't know if any job specification goes to the circumference of ankles except in the chorus line.

Q. At page 2 of your testimony, Doctor, you suggest

that it is of some significance that woman doctors and nurses at the hospital often continue right up to the day of delivery. Are not the job requirements and potential hazardous exposures quite different from those of telephone workers than doctors and nurses?
A. That is not within my competence to answer. That would mean I know the full telephone business which I do not. I am saying there is nothing inherently in the pregnant state that eliminates work as a factor and it is best shown that those who most deal with pregnancy, namely obstetricians, nurses, pediatric interns, continue right up to delivery time.

Q. On page 3 of your testimony, Doctor, you refer to a large-scale analysis of work in pregnancy which compares results of pregnancy outcome between women with higher social classes and incomes and those with lower social classes and incomes. What is the study to which you refer? A. It is a study mentioned by an A. W. Didle–can I consult the exact reference for a moment?
PRESIDING EXAMINER: Yes, surely.
THE WITNESS: It is in the Journal of Occupational Medicine, January, 1970, Volume 2, Number 1, page 10 to 15, by A. W. Diddle, Gravid Women at Work, Fetal and Maternal Morbidity, Employment Policy, and Medicolegal Aspects.
BY MR. LEVY:

Q. Was that study conducted by or under the auspices of the government? A. Yes, Vital Health Statistics. The person who did it, I think, was Mary Jane Covar.

* * *

Q. Doctor, in that study which I have just had a moment to glance at quickly, is lower income identified as the sole and crucial factor in the correlations involved?
A. That is one of the core problems in all of the studies. Of course, you can get studies in every single way about work, who works, and who does not work. One of the problems involved in unraveling who works and who does not work so you can show a direct cause and effect relationship, it is precisely because I don't know of any study that has ever been able to keep all the variable constant and manipulate only one which would be the proper scientific design. I don't know of any study that has done that. So that what we are talking about here is that there is a constant association between income and bad pregnancy outcome.

Q. But it is possible that the positive correlation to which you refer between social class and pregnancy outcome may be the result of many different variables including but even apart from income per se.
A. That is a priori scientifically always true that associations between two phenomena may be due to third and fourth phenomena that we have not considered yet like the phase of the moon, whether you were born under Capricorn. All I can say is scientifically there is no data at the present time which shows anything but that low income always leads to that outcome. Excuse me, let me correct that. Low income does not always lead to that outcome. All studies show correlationship between low income and high income. It is the problem of the Negro, the poor, and so on. That is constant.

* * *

Q. Doctor, what about differences in diet apart from income?Would they not possibly correlate?

A. The difficulty is precisely that diet is so heavily related to income that it has always been assumed in medicine that that is precisely why the income is so important. It allows you to buy first-rate proteins and this kind of thing. It is precisely why one would not wish to cut someone off from their income if that will be their source of first-class proteins, and doctors have expenses. It is always nice to be able to afford your own.

Q. What about differences in health education or knowledgeability between higher and lower social classes?
A. Clear correlations at any given time between higher social economic classes and higher income, higher degree of learning, more years of college and so forth, better diets, that is precisely the problem of poverty at any time.

Q. Is there generally a correlation also between higher social class and better preparation care, better pre- and post-delivery case as compared to lower socio-economic scales? A. Yes. If you can pay your own way you are better off than going to D.C. General and waiting several hours in the wings. There is no question about it.
MR. LEVY: I have no further questions.
PRESIDING EXAMINER: On this page 3, Dr. Hellegers, you refer to poorer outcome of pregnancy and better outcome. Is this in terms of live versus stillborn?
THE WITNESS: Live versus newborn, neonatal newborn, and non-premature deaths and mature versus premature.
PRESIDING EXAMINER: Thank you. Mrs. Baker?
BY MRS. BAKER:

Q. You mentioned in your responses earlier that during the first trimester the danger seemed the greatest. Was that to the child or to both the mother and the child? A. To the child.

Q. I think we are talking perhaps about three different

areas of possible danger and harm. One would be to the baby, one would be to the mother and the third one might be others resulting from the mother's condition. For instance, a woman who may be operating and might faint, might cause some harm to her fellow workmen. The question is: Would this harm be any greater than if a man fainted on a job?Is there something particular about pregnancy which means when something happens to the woman it is any worse than if it happens to a non-pregnant human being? A. Let me answer two ways: For the pregnant woman to faint and fall is to herself apart from the fetus no more dangerous than it is for a man to fall.

Q. To those around her? A. My sort of crazy mind would say would you rather have a 100 pound woman fall on top of you or a 250 pound man?More to the point would be your third category which is the fetal category and from the falling point of view, if fainting or falling in the first trimester could make you miscarry or something like that, you know we wouldn't have the abortion legislation fights that we have now today because every woman would drop down and abort it. Unfortunately, or fortunately, one cannot expel a fetus by falling or all legal abortionists would be out of business.

Q. Do you find that all women lose tremendous amount of dexterity, stamina, during pregnancy, or is this subject to individual variation? A. It is individual. It depends on the weight gained and it depends on the starting weight. Let me try to explain this. If a woman is pregnant and weighs 160 pounds to start with, the 20-pound weight gain on her represents obviously much less of a problem than if the 20-pound weight were to start in a girl who weighed 80 pounds. It is a

fraction of weight carried so one can already begin to individualize on that one in very much the same way as sudden weight gain among men. A 100 pound man who turns obese is affected more than the man who is obese to start with.

Q. Are all pregnant women subject to a tremendous amount of edema? A. No, it is usually that category of women who have what is called toxemia.

Q. Is exercise contraindicated in edema? A. No.

Q. Can a pregnant woman lift, let us say, 20 pounds when pregnant if she is capable of doing so?Will it harm her or her child if she is lifting 20 pounds four times a day and she keeps lifting 20 pounds four times a day, should she be able to do this through her pregnancy?It is like lifting a cow, you can never start that way.

A. I am bothered by the generality of the question. Lifting 20 pounds of weight is different for the 80-pound woman from the 160-pound woman. Now let me answer it is contraindicated to lift children anyone can go into any American home where there is a first child and the second child and you see pregnant woman lifting children. Or, you can go to the supermarket and find pregnant women holding onto two pounds. There are pregnant nurses who lift their patients. They are more savvy, of course, about lifting.

Q. Can pregnant women overreach with their arms?Is there anything about pregnancy than would indicate that a woman should not reach right through pregnancy?

A. There is nothing in the pregnancy that tells she could not reach but I remind you again she does carry the weight in front of her and that is an obvious fact. Nothing can happen to her. She can't have the baby or go into labor.

Q. And that would depend on the woman's own

feeling to do it every day Provided they can get up to the desk or whatever, if they are physically capable because of the weight in front of them–

A. There is nothing short in the pregnancy other than the physical mass that contraindicates, bending, lifting, and so on.

Q. Just because a woman is nine months pregnant, there is tremendous variation on how much incapacitated, if any, they are? A. So many women have babies of which we say, gosh, I hardly knew she was pregnant. She does not show, is the common expression. Others show very clearly.

Q. Would the same thing go for bending or spending a number of hours sitting? A. Sure. Pregnant women do hardly anything but that when they are home, bend, lift – that is the common state of a pregnant woman.

MRS. BAKER: I think that is all.

PRESIDING EXAMINER: Do you have anything further, Mr. Copus?

MR. COPUS: No, Mr. Examiner, we have no questions on redirect.

PRESIDING EXAMINER: Thank you, Doctor. You are excused. (Witness excused)

PRESIDING EXAMINER: Do I understand that is all we have in the way of testimony today?

MR. COPUS: Yes, sir.

PRESIDING EXAMINER: We will adjourn at this time until 9 o'clock on Wednesday morning.

PLAINTIFFS' EXHIBIT NO. 89
Maternity Benefits Provisions for Employed Women, U.S. Dept. of Labor

IV

LEGISLATION AND REGULATION IN THE UNITED STATES

The United States has more legislation that provides maternity protection for women workers than is generally realized. Well-known laws are the Federal Railroad Unemployment Insurance Act providing weekly cash maternity benefits to women in the railroad industry; the Rhode Island Cash Sickness Compensation Act providing weekly cash maternity benefits to women workers in that State; and the laws of six States and Puerto Rico prohibiting employment for specified periods before and after childbirth–in Puerto Rico with half-pay.

Less familiar are laws and regulations making protection available to many thousands of other women workers. Included in these provisions are income tax deductions for sick pay received during illness in pregnancy; leave with pay for over half a million Federal civilian women employees; and maternity medical care for women in the armed services, in several Federal civilian agencies, and, after July 1, 1960, in all Federal civilian agencies.

Included also are provisions for women workers who benefit indirectly, i.e., not through their own connections with a job but as dependents. Such provisions apply to 98,000 employed wives of men in the armed services, to the working wives of men in certain Federal civilian agencies, and–after July 1, 1960–to the wives of all men in the Federal civilian Government who elect family coverage.

Still other women who benefit, also, not directly as workers but as "medically needy" when they must give up their jobs because of pregnancy, are thousands of beneficiaries of Federal, State, and local provisions for maternity medical care.

More detailed information regarding the above laws and regulations, as well as experience under them, follows.

Federal Legislation and Regulations

Federal Income Tax Deduction

Applicable to all women workers whose employment entitles them to sick pay is a provision of the Federal income tax law allowing a deduction from taxable income for sick pay received while a worker is absent because of illness during pregnancy. Pay received for periods of absence due *solely* to pregnancy is not deductible; but if the absence is due to *illness during pregnancy*, part or all of the sick pay received is deductible, whether the illness was the result of pregnancy or of some other cause. There is a waiting period of 1 week for which sick pay is not deductible, unless the employee is hospitalized; if she is hospitalized even for a day, sick pay for the entire period of her absence from work is deductible. No more than $100 a week is deductible, however, even if a larger amount of sick pay is received.

Railroad Unemployment Insurance Act [15]

The Railroad Unemployment Insurance Act provides for unemployment, sickness, and special maternity weekly cash benefits. The basic formula by which the amounts of benefits are determined is the same for all three types of benefits.

The Act has been amended several times, most lately on May 19, 1959, effective immediately. [16] The main purpose of amendments after 1946 has been to raise benefits so that they would keep pace with earnings, and to adjust the financing of the program to the cost experience.

Under the 1959 Amendment, a woman must have earned at least $500 of railroad wages in a base year (calendar year) in order to qualify for maternity benefits in the benefit year, which begins the following July 1. If her earnings were at least $500 in 1958, she is qualified in the period July 1, 1959–June 30, 1960.

Her daily benefit rate will be determined in one of two ways, whichever will provide the higher rate, though in neither case may it exceed $10.20. Her rate will either be:

(a) Sixty percent of her daily rate of pay on her last railroad job in the base year; or

(b) Based on the following schedule:

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[15] 52 Stat. 1094. As originally enacted in 1938, effective July 1, 1939, the law provided for the payment of benefits only to unemployed railroad workers who were "available for work." In 1946, effective July 1, 1947, the Act was amended (Public Law 572. 79th Cong., 2d sess, 1946) to provide weekly cash benefits for railroad workers who are unable to work because of sickness; also provided are special maternity benefits to women railroad workers.

[16] June 23, 1948: 62 Stat. 576 578; Oct. 30, 1951: 65 Stat. 691; May 15, 1952; 66 Stat. 700; Aug. 31, 1951: 68 Stat. 1011; Aug. 12 1955: 69 Stat. 716; May 19, 1959: Public Law 86 28, 86th Cong., 1st sess., (H.R. 5610), 1959.

For Employed Women

Employee's creditable basic-year earnings	*Daily benefit rate*
$500 to $699.99	$ 4.50
$700 to $999.99	5.00
$1,000 to $1,299.99	5.50
$1,300 to $1,599.99	6.00
$1,600 to $1,899.99	6.50
$1,900 to $2,199.99	7.00
$2,200 to $2,499.99	7.50
$2,500 to $2,799.99	8.00
$2,800 to $3,099.99	8.50
$3,100 to $3,499.99	9.00
$3,500 to $3,999.99	9.50
$4,000 and over	10.20

The new rates are retroactive to July 1, 1958.

There is no waiting period for maternity benefits. To receive benefits, the claimant must file pertinent information, including statements from a doctor on the expected and on the actual date of birth of her child.

Benefits are payable for a total of 116 days, or approximately 16½ weeks. They may begin 57 days (about 8 weeks) before the *expected* delivery date, but in no case may the claimant be paid for more than 84 days before *actual* childbirth. If the full 84 days before the date of delivery are paid, days paid after delivery may not exceed 31.

Since the first 14 days of the maternity period and the 14 days immediately after the birth of the child are paid for at 1½ times the daily rate, the total maximum benefit available is equal to 130 times the daily allowance. Total benefits available therefore range from $485, payable to women with earnings between $500 and $699.99 in the base year, to $1,326 to women who have earned $4,000 or more.

During the 11 years the 1946 Amendment establishing

sickness and maternity benefits has been operative,[17] the number of women railroad workers who have received maternity benefits has fluctuated in a relatively small range centering around 4,000. In the 1957-58 benefit year they numbered 3,900, and they then represented about 4 percent of all qualified women.

Women are only a small proportion of all railroad workers–6 percent in 1956, or 97,800 out of a total of 1,627,900. The majority of these women (two-thirds in 1955) are office workers–in 1957, nine out of ten.

The occupations of the 3,900 women who were beneficiaries in the 1957-58 benefit year were:

Occupation	*Number of employees*
Office employees:	
Executives, supervisors, and professionals	100
Station agents and telegraphers	100
Clerks and other office employees	3,400
All other employees	300

The great majority of beneficiaries that year were under age 35 and were divided evenly between women 25 to 34 years old and those under age 25, as the following grouping shows:

Age group	*Number*
Under 25	1,700
25–34	1,700
35–44	400
45 and over	100

[17] Information in this section on the operation of the maternity benefit provisions of the Railroad Unemployment Insurance Act are from: (1) Railroad Retirement Board, The Monthly Review, Feb. 1959; and (2) Railroad Retirement Board, *Annual Report 1958* for the Fiscal Year Ended June 30, 1958.

The average duration of benefits, that is, the average number of days benefits were paid per beneficiary, have ranged from 102 to 113 (109 in 1957–58); and the average total amount of benefit has risen from $456 in 1947–48 to $963 in 1957–58. Benefits in 1957–58 were distributed as follows:

	Maternity beneficiaries	
	Number	*Percent*
Total	3,900	100
Less than $400	(1)	1
$400 to $499	100	2
$500 to $599	200	4
$600 to $699	100	2
$700 to $799	200	5
$800 to $899	300	7
$900 to $999	800	20
$1,000 to $1,099	1,400	38
$1,100 to $1,105	800	21

[1]Fewer than 50

Eighty-one percent of the pregnancy claims were not terminated until completion of the 116 days limitation period.

PLAINTIFFS' EXHIBIT NO. 90
Railroad Retirement Board Annual Report - 1971

Sickness

Some 85,900 railroad workers were paid sickness benefits totaling $50.1 million in 1970–71. The number of beneficiaries (6 percent less than in the preceding year) was the smallest in the history of the sickness program. The amount paid was down 13 percent from the near-record total paid in 1969–70. The percentage decrease was about the same for normal and extended benefits; extended payments accounted for 18 percent of the total amount paid both in 1969–70 and in 1970–71. Benefits continued to average $63 for a full week of sickness, before adjustments for withholdings or recoveries due to receipt of other payments. After adjustment, the average weekly amount was approximately $56.

* * *

The median age of all sickness beneficiaries was 54 years, compared with 49 years for employees qualified in the 1970–71 benefit year. Even though extended sickness benefits are not payable to beneficiaries who have attained age 65, the median age of those on the extended rolls was higher–57 years. The 7,500 women beneficiaries had a median age of 45 years. Almost one-fourth of them were paid for conditions associated with pregnancy and childbirth.

PLAINTIFFS' EXHIBIT NO. 91
Railroad Retirement Board Annual Report 1969.

Sickness

Sickness benefit totals in 1968–69 were above the levels of the 2 preceding years, despite a decline of about 25,000 from 1967–68 in the number of qualified employees.

* * *

The total number of beneficiaries included about 300 women who were paid maternity benefits for days before July 1, 1968. The 1968 amendments eliminated maternity benefits as such, but some 1,900 women received regular sickness benefits for days in 1968–69 because of pregnancy, miscarriage, or childbirth. About 2,000 women had received maternity benefits in the preceding year.

* * *

PLAINTIFFS' EXHIBIT NO. 92
Beneficiaries Under the RUIA, Railroad Retirement Board Quarterly Review, January-March, 1972.

Table 2.—Beneficiaries, benefit averages, and related data for 1970-71 sickness, by major sickness group

International list no.	Type of sickness group	Beneficiaries					Average per beneficiary			
		Number		Percent						
		Total	Female	Exhausting normal benefits	Paid both normal and extended benefits[1]	Affected by adjustments for other payments	Median age at end of 1970	Creditable days of sickness	Daily benefit	Amount of benefits for year
	Total	79,200	7,300	15	13	13	54	91	$11.21	$689
000-136	Infective and parasite diseases	1,800	200	11	9	9	51	71	11.62	540
140-239	Neoplasms	3,200	600	14	12	11	56	90	11.62	699
240-279	Endocrine, nutritional and metabolic diseases	2,000	200	21	21	21	56	111	10.90	820
280-289	Diseases of the blood and blood-forming organs	400	100	(2)	(2)	(2)	(2)	(2)	(2)	(2)
290-315	Mental disorders	2,800	500	20	17	13	49	112	11.09	840
320-389	Diseases of the nervous system and sense organs	3,100	200	18	16	20	56	103	10.80	750
390-458	Diseases of the circulatory system	14,800	700	22	21	24	57	116	10.55	832
460-519	Diseases of the respiratory system	7,700	600	13	12	13	55	76	10.90	546
520-577	Diseases of the digestive system	10,500	600	7	7	7	53	70	11.85	545
580-629	Diseases of the genito-urinary system	3,900	300	5	5	7	56	59	11.67	443
680-709	Diseases of the skin and subcutaneous tissue	1,100	100	12	9	5	52	72	11.87	559
710-738	Diseases of the musculoskeletal system and connective tissues	5,900	400	23	21	20	56	113	10.72	824
780-796	Symptoms and ill-defined conditions	5,700	500	15	14	11	52	88	11.37	668
800-999	Accidents, poisoning and violence	14,700	700	14	11	9	47	86	11.80	675
(3)	Pregnancy, childbirth, and the puerperium	1,700	1,700	13	1	(4)	25	110	12.69	947

[1] Extended benefits either preceding or following normal benefits.

[2] Number in sample too small to yield reliable data.

[3] Includes normal pregnancies and childbirths plus a small number of cases involving morbidities classified under numbers 630-678.

[4] Less than 0.5.

NOTE. Data based on a 20 percent sample of beneficiaries. Type of sickness is determined by first sickness for which payment was made or waiting-period credit given. Classification by sickness group is in accordance with *Manual of the International Statistical Classification of Diseases, Injuries, and Causes of Death*, Eighth Revision, World

The number of women on the sickness rolls (7,300) was about the same as in 1969–70 and women again accounted for 9 percent of the beneficiaries. Their Beneficiary rate remained at 15 per 100 qualified employees while the beneficiary rate for men declined from 11 to 10 per 100. Women had a longer average duration of disability and received a higher average amount than men even though the percentage receiving extended benefits was higher for men than women. Pregnancy accounted for a slightly higher percentage (23 percent) of the female sickness beneficiaries than in 1969–70. The median age for women beneficiaries declined to 44 years from 46 in the previous year while the median age for men remained at 54 years.

* * *

Table 2. Beneficiaries, benefit averages, and related data for 1969-70 sickness, by major sickness group

International list no.	Type of sickness group	Beneficiaries						Average per beneficiary		
		Number		Percent			Median age at end of 1969	Creditable days of sickness	Daily benefit	Amount of benefits for year
		Total	Female	Exhausting normal benefits	Paid both normal and extended benefits [1]	Affected by adjustments for other payments				
	Total	85,400	7,300	18	15	10	54	99	$11.17	$740
001-138	Infective and parasitic diseases	1,400	200	10	9	5	51	68	11.83	525
140-239	Neoplasms	3,300	600	17	16	8	56	98	11.51	757
240-289	Allergic, endocrine system, metabolic, and nutritional diseases	2,600	200	22	20	13	56	109	10.95	807
290-299	Diseases of the blood and blood-forming organs	200	100	(2)	(2)	(2)	(2)	(2)	(2)	(2)
300-326	Mental, psychoneurotic, and personality disorders	3,000	600	20	17	8	48	105	11.54	814
330-398	Diseases of the nervous system and sense organs	4,600	200	31	28	19	57	139	10.48	988
400-468	Diseases of the circulatory system	14,200	800	29	25	19	57	135	10.40	957
470-527	Diseases of the respiratory system	9,900	700	12	10	8	55	69	11.21	508
530-587	Diseases of the digestive system	11,800	600	9	7	6	54	75	11.73	581
590-637	Diseases of the genito-urinary system	3,800	300	10	8	9	56	70	10.99	505
690-716	Diseases of the skin and cellular tissue	1,200	100	12	8	3	51	68	12.02	538
720-749	Diseases of the bones and organs of movement	6,200	500	27	21	15	55	123	10.84	902
780-795	Symptoms, senility, and ill-defined conditions	5,000	400	15	13	8	53	88	11.39	665
800-999	Accidents, poisonings, and violence	16,600	700	16	13	7	48	94	11.90	744
(3)	Pregnancy, childbirth, and the puerperium	1,500	1,500	9	1	(4)	25	107	12.66	922

[1] Extended benefits either preceding or following normal benefits.

[2] Number in sample too small to yield reliable data.

[3] Includes normal pregnancies and childbirths plus a small number of cases involving morbidities classified under numbers 640-689.

[4] Less than 0.5.

NOTE—Data based on a 20-percent sample of beneficiaries. Type of sickness is determined by first sickness for which payment was made or waiting period credit given. Classification by sickness group is in accordance with *Manual of the International Statistical Classification of Diseases, Injuries, and Causes of Death*, Seventh Revision, World Health Organization. Includes all major groups in which there were 50 or more beneficiaries.

As in 1968-69, women accounted for 9 percent of the beneficiaries. The median age of the men was 54 years and that of the women 46 years, both the same as in the preceding year. The most common causes of disability among the men were injuries, circulatory diseases, and digestive ailments, in that order. Among the women, pregnancy and childbirth were the most common conditions for which benefits were paid, followed by circulatory ailments.

PLAINTIFFS' EXHIBIT NO. 95
Washington State Human Rights Commission,
New Employment Regulations, Maternity Leave
Policy, adopted 6-22-72, effective 7-26-72.

WASHINGTON STATE HUMAN RIGHTS COMMISSION
NEW EMPLOYMENT REGULATIONS
MATERNITY LEAVE POLICY

WAC 162-30-020. MATERNITY. (1) *Findings and Purposes.* Childbearing is an expectable incident in the life of a woman. Practices such as terminating pregnant women from employment and not hiring young women for responsible jobs because they may become pregnant and have to be terminated have contributed substantially to present conditions of lack of job opportunity for women limitation of women to low-paying clerical jobs, and lack of opportunity for women to advance to levels of employment enjoyed by men of equal ability. It is the objective of the law against discrimination in employment because of sex, Chapter 49.60 RCW, to equalize employment opportunity for men and women. This regulation defines how that law applies to childbearing by women workers.

* * *

(5) *Leave Benefits.* Disabilities caused or contributed to by pregnancy, miscarriage, abortion, childbirth, and recovery therefrom are, for all job-related purposes, temporary disabilities and should be treated as such under any health or temporary disability insurance or sick leave plan available in connection with employment. Written and unwritten employment policies and practices involving matters such as the availability of extensions of leave time, the accrual of benefits and privileges, such as seniority, retirement, pension rights, and other service credits and benefits, and payment under any health or temporary disability insurance or sick leave plan, formal or informal, shall be applied to disability due to pregnancy or childbirth on the same terms and conditions as they are applied to other temporary disabilities.

(6) *Insurance Benefits.* If an employer provides maternity insurance coverage to wives of male employees, the same coverage must also be provided to female employees.

* * *

PLAINTIFFS' EXHIBIT NO. 97
U.S. Dept. of Health, Education and Welfare
National Center for Health Statistics, Series 22,
No. 15, Infant Mortality Rates: Relationship
with Mother's Reproductive History (GPO 1973).

Infant Mortality Rates: Relationship With Mother's Reproductive History

Table 17. Estimated average annual number of live births and infant deaths per 1,000 live births, by live-birth order, family income, and race of infant: United States, 1964-66 legitimate, single births

Race and live-birth order	Live births				Infant deaths			
	All infants	Family income			All infants	Family income		
		Less than $3,000	$3,000-$4,999	$5,000 or more		Less than $3,000	$3,000-$4,999	$5,000 or more
All races	Number in thousands				Rate per 1,000 live births			
All birth orders	3,417	679	767	1,971	21.7	30.5	23.7	17.9
First	1,004	247	230	526	18.1	22.9	18.4	15.6
Second	857	146	201	510	22.0	32.6	23.9	18.2
Third	610	87	139	385	22.2	40.2	25.9	16.8
Fourth	392	58	86	248	21.2	26.7	23.4	19.1
Fifth	228	44	48	136	25.2	33.9	25.9	22.2
Sixth or more	326	98	64	165	29.7	38.8	36.4	21.8

White							
All birth orders	2,961	461	660	1,840	19.5	26.0	20.8	17.5
First	907	205	210	492	16.3	20.5	15.4	15.0
Second	759	103	176	480	20.1	25.0	23.3	17.8
Third	536	56	118	362	20.1	36.3	22.6	16.7
Fourth	342	33	70	239	19.5	19.1	21.9	18.8
Fifth	191	25	43	123	20.5	22.4	17.1	21.4
Sixth or more	226	39	43	144	28.8	51.0	34.0	21.1
Black								
All birth orders	402	202	94	106	37.6	40.4	44.6	26.1
First	83	40	19	25	38.1	36.0	*	31.4
Second	81	39	19	22	39.4	49.2	*	*
Third	66	28	17	20	39.5	45.5	*	*
Fourth	45	23	14	8	34.2	*	*	*
Fifth	33	17	5	11	51.4	*	*	*
Sixth or more	94	55	20	19	31.1	32.3	*	*

PLAINTIFFS' EXHIBIT NO. 98
Variations in Birth Weight, Legitimate Live Births, United States 1963.

Variations in Birth Weight

Legitimate Live Births

Table 3. Average birth weight, number of births, and percent distribution, by birth-weight interval according to family income in 1962 and color of mother: United States, 1963 legitimate live births

1962 family income and color	Average birth weight	Births	Birth weight					
			Total	2,500 grams or less	2,501-3,000 grams	3,001-3,500 grams	3,501-4,000 grams	4,001 grams or more
All incomes	Grams	Number in thousands	Percent distribution					
Total	3,280	3,797	100.0	7.2	19.4	39.2	26.1	8.0
White	3,300	3,315	100.0	6.5	18.8	39.1	27.1	8.5
Nonwhite	3,130	482	100.0	11.8	23.7	40.0	19.8	4.7
Under $3,000								
Total	3,180	819	100.0	10.4	21.6	39.2	23.2	5.6
White	3,200	570	100.0	8.8	20.1	38.9	26.3	5.9
Nonwhite	3,080	249	100.0	14.0	25.0	39.8	16.2	5.0
$3,000-$4,999								
Total	3,280	1,030	100.0	7.7	18.7	39.8	25.0	8.8
White	3,300	879	100.0	6.9	18.2	40.2	25.0	9.7
Nonwhite	3,160	151	100.0	12.4	21.7	37.1	24.8	3.9
$5,000-$6,999								
Total	3,310	920	100.0	5.7	18.1	39.6	28.2	8.4
White	3,310	876	100.0	6.0	17.8	39.1	28.4	8.6
Nonwhite	3,300	44	100.0	-	22.4	50.4	23.5	3.7
$7,000 and over								
Total	3,330	973	100.0	5.5	19.6	38.0	28.4	8.6
White	3,330	930	100.0	5.4	19.5	38.0	28.6	8.6
Nonwhite	3,190	34	100.0	9.6	23.3	37.6	21.6	7.9
$7,000-$9,999								
Total	3,330	667	100.0	5.0	20.5	36.8	29.1	8.6
White	3,340	645	100.0	4.8	20.3	36.9	29.1	8.8
Nonwhite	3,190	22	100.0	9.7	25.5	32.0	29.4	3.5
$10,000 and over								
Total	3,310	306	100.0	6.8	17.6	40.6	26.6	8.5
White	3,320	294	100.0	6.7	17.5	40.3	27.4	8.2
Nonwhite	*	*	*	*	*	*	*	*
Unknown								
Total	3,300	55	100.0	3.5	20.9	45.8	18.4	11.3
White	3,320	51	100.0	3.8	20.3	43.9	19.8	12.2
Nonwhite	*	*	*	*	*	*	*	*

Table 11. Average birth weight, number of births, and percent distribution, by birth-weight intervals according to family income in 1962 and trimester of first visit for medical care: United States, 1963 legitimate live births

1962 family income and trimester of first visit	Average birth weight	Births	Birth weight					
			Total	2,500 grams or less	2,501-3,000 grams	3,001-3,500 grams	3,501-4,000 grams	4,001 grams or more
	Grams	Number in thousands	Percent distribution					
All incomes								
All trimesters	3,280	3,797	100.0	7.2	19.4	39.2	26.1	8.0
First	3,300	2,246	100.0	6.7	18.2	39.4	27.2	8.5
Second	3,230	724	100.0	7.5	20.4	41.7	23.9	6.6
Third	3,250	679	100.0	8.6	23.2	35.3	25.8	7.2
No prenatal care	3,250	79	100.0	11.5	12.0	41.9	24.1	10.5
Trimester unknown	3,370	69	100.0	1.7	21.0	44.6	21.3	11.5
Under $3,000								
All trimesters	3,180	819	100.0	10.4	21.6	39.2	23.2	5.6
First	3,140	348	100.0	11.9	21.2	38.5	23.6	4.8
Second	3,160	212	100.0	11.0	20.8	42.0	22.2	4.0
Third	3,220	215	100.0	8.6	25.3	37.0	21.8	7.2
No prenatal care	3,420	35	100.0	5.9	10.4	39.9	29.0	14.8
Trimester unknown	*	*	*	*	*	*	*	*
$3,000-$4,999								
All trimesters	3,280	1,030	100.0	7.7	18.7	39.8	25.0	8.8
First	3,310	562	100.0	6.7	17.7	39.8	26.0	9.8
Second	3,260	233	100.0	5.3	21.3	42.1	22.8	8.5
Third	3,200	208	100.0	12.3	19.2	38.0	24.7	5.8
No prenatal care	3,150	21	100.0	17.8	12.5	33.0	27.2	9.6
Trimester unknown	*	*	*	*	*	*	*	*
$5,000-$6,999								
All trimesters	3,310	920	100.0	5.7	18.1	39.6	28.2	8.4
First	3,320	615	100.0	5.6	17.5	39.4	29.0	8.6
Second	3,270	151	100.0	6.8	14.7	46.0	25.6	6.8
Third	3,320	140	100.0	4.5	23.9	32.9	29.3	9.3
No prenatal care	*	*	*	*	*	*	*	*
Trimester unknown	*	*	*	*	*	*	*	*
$7,000 and over								
All trimesters	3,330	973	100.0	5.5	19.6	38.0	28.3	8.6
First	3,340	718	100.0	5.2	17.8	39.5	28.5	9.0
Second	3,260	126	100.0	6.4	24.4	35.1	26.9	7.1
Third	3,220	115	100.0	6.7	25.8	29.3	30.9	7.3
No prenatal care	*	*	*	*	*	*	*	*
Trimester unknown	*	*	*	*	*	*	*	*
Unknown								
Total	3,300	55	100.0	3.5	20.9	45.8	18.4	11.3

Table 12. Average birth weight, number of births, and percent distribution, by birth-weight intervals according to family income in 1962 and number of visits: United States, 1963 legitimate live births

1962 family income and number of visits	Average birth weight	Births	Birth weight					
			Total	2,500 grams or less	2,501-3,000 grams	3,001-3,500 grams	3,501-4,000 grams	4,001 grams or more
	Grams	Number in thousands	Percent distribution					
All incomes								
All visits	3,280	3,797	100.0	7.2	19.4	39.2	26.1	8.0
No visits	3,230	79	100.0	11.5	12.0	41.9	24.1	10.5
1-4 visits	3,170	676	100.0	10.2	26.0	34.8	22.7	6.3
5-9 visits	3,200	699	100.0	10.6	19.5	39.5	24.5	5.9
10-14 visits	3,310	1,132	100.0	5.6	19.2	38.9	28.4	7.9
15-19 visits	3,360	697	100.0	3.9	17.3	42.1	26.7	10.1
20 visits or more	3,350	430	100.0	6.1	14.0	41.4	28.2	10.3
Unknown	3,310	83	100.0	5.2	22.4	39.9	22.9	9.6
Under $1,000								
All visits	3,180	819	100.0	10.4	21.6	39.2	23.2	5.6
No visits	3,420	35	100.0	5.9	10.4	39.9	29.0	14.8
1-4 visits	3,130	217	100.0	12.8	26.1	34.7	20.5	5.9
5-9 visits	3,120	203	100.0	13.7	20.0	42.0	20.4	4.0
10-14 visits	3,230	198	100.0	8.2	21.2	36.6	28.5	5.5
15-19 visits	3,230	104	100.0	5.9	21.3	43.6	21.7	7.6
20 visits or more	3,200	52	100.0	10.0	15.4	49.4	23.4	1.9
Unknown	*	*	*	*	*	*	*	*
$1,000-$4,999								
All visits	3,280	1,030	100.0	7.7	18.7	39.8	25.0	8.8
No visits	3,150	21	100.0	17.8	12.5	33.0	27.2	9.6
1-4 visits	3,150	206	100.0	11.0	23.0	40.1	21.3	4.5
5-9 visits	3,220	225	100.0	9.0	20.4	37.2	27.4	6.1
10-14 visits	3,330	284	100.0	5.2	16.4	43.5	26.3	8.6
15-19 visits	3,320	174	100.0	6.6	20.6	40.4	20.0	12.4
20 visits or more	3,440	112	100.0	5.5	10.9	35.5	31.8	16.3
Unknown	*	*	*	*	*	*	*	*
$5,000-$6,999								
All visits	3,310	920	100.0	5.7	18.1	39.6	28.2	8.4
No visits	*	*	*	*	*	*	*	*
1-4 visits	3,160	115	100.0	9.0	29.2	28.2	26.7	6.9
5-9 visits	3,220	162	100.0	8.4	17.4	43.8	26.1	4.4
10-14 visits	3,360	313	100.0	5.0	17.6	36.6	30.8	10.0
15-19 visits	3,390	193	100.0	2.1	14.2	44.7	29.5	9.5
20 visits or more	3,330	118	100.0	5.2	16.1	43.2	25.9	9.6
Unknown	*	*	*	*	*	*	*	*
$7,000 and over								
All visits	3,330	973	100.0	5.5	19.6	38.0	28.3	8.6
No visits	*	*	*	*	*	*	*	*
1-4 visits	3,280	138	100.0	6.3	27.1	32.4	25.0	9.0
5-9 visits	3,260	107	100.0	11.8	20.2	32.8	24.6	10.5
10-14 visits	3,300	335	100.0	4.8	21.8	38.7	28.0	6.7
15-19 visits	3,430	225	100.0	2.3	15.7	40.1	31.9	10.0
20 visits or more	3,340	148	100.0	6.0	14.2	41.5	29.1	9.2
Unknown	*	*	*	*	*	*	*	*
Income unknown								
Total	3,300	55	100.0	3.5	20.9	45.8	18.4	11.3

PLAINTIFFS' EXHIBIT NO. 99
U.S. Dept. of HEW, National Center for Health Statistics. Series 22, No. 12, Health Insurance Coverage for Maternity Care: Legitimate Live Births, U.S. 1964-1966 (GPO 1971)

Health Insurance Coverage for Maternity Care: Legitimate Live Births

• • •

Among mothers of legitimate live births during 1964-1966 there was an annual average of 59 percent of mothers who had insurance to pay the physician bills for office visits or home calls during pregnancy, the physician bills for delivery of the baby, or the bills for hospital care at the time of delivery (table 2).

• • •

PLAINTIFFS' EXHIBIT NO. 100

EEOC Guidelines on Advance of Sick Leave

N-566
May 25, 1973

1. SUBJECT. GUIDELINES ON ADVANCE OF SICK LEAVE

2. PURPOSE. This Notice provides the CSC prescribed guidelines which the Personnel Division follows in acting on an employee's request for advance of sick leave. This Notice supplements EEOC Manual Section 911, Leave (November 15, 1968; revised July 25, 1969).

3. ORIGINATOR. Personnel Division, Office of Management.

4. GUIDELINES. U.S. Civil Service Commission regulations indicate that advance of sick leave should be granted in cases of serious disability only. A serious disability would, in most instances, require a period of hospital confinement. Accordingly, requests for advance of sick leave will be approved providing the following conditions exist:

(a) necessity for hospital confinement;

(b) reasonable expectation that the person will recover from the disability and return to full duty status;

(c) reasonable cause to believe the employee will remain with the Federal government for a sufficient period to repay the advance of sick leave;

(d) recommending official deems the granting of the advance of sick leave to be in the best interest of the Federal Government and requests approval.

Requests for advance of sick leave for reasons of pregnancy and confinement should be treated the same as requests for advance of sick leave in other cases of serious disability regardless of the maternity aspect.

The EEOC maternity leave policy permits up to six months of leave – sick, annual, leave without pay, or any combination thereof. In some instances, the time period can be extended.

5. REQUESTING ADVANCE OF SICK LEAVE. Requests for approval of the advance of sick leave are to be forwarded to the Personnel Division with a doctor's certificate attached. Failure to adhere to the above will result in the request for advance sick leave being denied.

6. OBSOLETE DATA. Memoranda from Ronald B. Krueger, Personnel Office, subject: Advanced Sick Leave (12/20/72) and Advance Sick Leave (1/26/73).

Approved: Yvette D. Butler
Director, Office of Management

Approved: T.G. Cody
Executive Director

PLAINTIFFS' EXHIBIT NO. 101

Department of Transportation, Office of the Secretary, Order re Absence and Leave 10-12-72 (OST 3600.1)

CHAPTER III SICK LEAVE

21. *ACCRUAL AND CREDIT*

a. *Amount of accrual*

(1) Full-time employees earn sick leave at the rate of 4 hours for each full biweekly pay period.

(2) Part-time employees with a regular tour of duty prescribed in advance earn sick leave at the rate of 1 hour for each 20 hours in a pay status not to exceed 4 hours in any full biweekly pay period.

b. *Maximum accrual.* There is no limitation as to the amount of sick leave that employees may accumulate. Unused sick leave remains to an employee's credit and is available for use in succeeding years.

22. *TRANSFER AND RECREDIT OF SICK LEAVE.* An employee's accrued sick leave will be transferred when the employee moves without a break in service between positions subject to the Leave Act. Unused sick leave will be recredited at the time of reemployment following a break in service of not more than 3 years. Sick leave will be transferred on an adjusted basis when an employee moves between different leave systems.

23. *USE AND GRANTING OF SICK LEAVE*

a. Sick leave is a form of "income protection insurance" provided by the Leave Act that permits employees to remain in a pay status while absent from duty because of illness, injury, pregnancy and confinement, or to obtain required medical, psychiatric, dental, or optical examination or treatment. It is also available to cover absences

from duty when an employee is required to give care and attendance to an immediate family member who has a contagious disease, or when through exposure to a contagious disease an employee's presence on duty would jeopardize the health of others.

b. Normally, employees absent because of illness will make reasonable efforts to notify their supervisors within a reasonable time, generally two hours after the time they are scheduled to report for duty. A medical certificate is normally required for absences of more than three work days and may be required for shorter absences because of illness when there is an indication of employee abuse of sick leave.

c. In cases of serious disability or ailment and when the exigencies of the situation require, not to exceed 30 days' sick leave may be advanced to a full-time employee.

d. Part-time employees with a regular scheduled tour of duty may be advanced sick leave on a pro-rata basis. For example, a part-time employee whose scheduled tour of duty is 20 hours per week, one-half that of a full-time employee, may be advanced 15 days of sick leave, one-half the advance that may be made to a full-time employee.

e. In determining if an advance should be made, the following guidelines must be observed:

(1) the absence is expected to last 5 or more consecutive workdays although the advance may be for less than the total absence;

(2) employees in a probationary or trial period may not be advanced more sick leave than they will earn in the remainder of their current service year unless it is determined that there is reasonable expectation that the employee's service will continue beyond the end of the year;

(3) the request for advanced sick leave must be in writing and accompanied by a medical certificate giving a diagnosis and a prognosis, including the physician's estimate of the date when the employee will be able to resume his regular duty; and

(4) the total amount of sick leave that may be advanced to an employee serving under a limited appointment or one which will be terminated on a specified date, may not exceed the amount that will be earned during the remainder of the appointment.

f. Advanced sick leave shall not be granted to an employee:

(1) who is absent because a member of the employee's immediate family has a contagious disease;

(2) who has filed an application for disability retirement; or

(3) who has signified an intention to resign or otherwise leave the Department.

g. Sick leave will be charged in one-hour units or multiples thereof. The minimum charge to sick leave for an absence is one hour.

CHAPTER IV MATERNITY LEAVE

31. *USE OF MATERNITY LEAVE.* Childbirth, and recovery from childbirth, for all job-related purposes, are temporary disabilities and should be treated as such for granting sick leave. Maternity leave is a period of approved absence for pregnancy and confinement. Sick leave, annual leave, and/or leave without pay may be granted to cover a period of absence for maternity reasons. Employees are encouraged to advise their supervisors soon after pregnancy is determined so that there will be maximum opportunity to plan for the later absence on maternity leave. If there is a question as to the physical ability of an employee to perform her job without hazard to her health, a medical

certificate from the employee's attending physician should form the basis for a decision as to when maternity leave shall commence. Normally, the period of maternity leave is about fourteen weeks. This period generally begins about six weeks before the expected date of delivery and extends about eight weeks beyond the date of delivery. If incapacitation continues for more than eight weeks after delivery, the normal rules for granting sick leave apply.

32. *APPROVAL OF LEAVE.* The approval of a request for maternity leave is contingent on the employee's intention to return to duty, the kind and amount of leave required, the instructions governing leave for maternity reasons and the requirements of management.

33. *GRANTING SICK LEAVE.* An employee who is pregnant shall be granted the sick leave to her credit upon presentation of a statement from her physician certifying that she is incapacitated for duty. The medical certificate should indicate the date after which continued presence at work is expected to be detrimental to the employee's health, the expected date of confinement, and the date through which the physician considers the employee probably will be incapacitated for duty after confinement.

34. *ADVANCING SICK LEAVE.* Requests for advance sick leave associated with normal pregnancy and confinement usually should be denied. However, in the event of complications arising from pregnancy or childbirth, the approving official must apply standards of judgment similar to those governing granting of advance sick leave in other cases of serious disability regardless of the maternity aspect.

PLAINTIFFS' EXHIBIT NO. 102

1973-1976 GE-IUE
Settlement Agreement

MEMORANDUM OF SETTLEMENT

BETWEEN

GENERAL ELECTRIC COMPANY

AND

INTERNATIONAL UNION OF ELECTRICAL, RADIO AND MACHINE WORKERS (AFL-CIO)

General Electric Company, hereafter referred to as "Company" and the International Union of Electrical, Radio and Machine Workers, AFL-CIO, hereafter referred to as "Union", acting for itself and on behalf of each of its Locals in settlement of their current collective bargaining negotiations, hereby agree as follows:

(1) The Union and Company agree upon a 1973-1976 Settlement Agreement, the provisions of which will be identical with the provisions of the 1970-1973 Settlement Agreement but with the modifications set forth in the appendices A, B, C, D and E attached hereto.

* * *

IN WITNESS WHEREOF the parties have set their hand and seal on this 6th day of June 1973

INTERNATIONAL UNION OF ELECTRICAL, RADIO AND MACHINE WORKERS, AFL-CIO

David C. Fitzmaurice
John H. Stanton

GENERAL ELECTRIC COMPANY
John R. Baldwin
C. R. Grisey
William G. Aregall

Appendix B

GE-IUE Benefit Increases 1973-76

Pensions

full retirement at age 62, with a reduction of 6% at age 61, and 12% at age 60 (7/1/73);

* * *

a new supplemental payment of up to $150 per month for those retiring between ages 60 and 62 (7/1/73);

* * *

Sick Pay

2 days from 1 to 4 years of service–1 day now and 1 more day beginning 1/1/74;

accumulate and carry forward a maximum of 10 days (1/1/74);

use of absences other than personal illness (snow storms, floods, inventory days, etc.) (1/1/74).

Death in Family

expand paid absences to cover grandparent-in-law, brother-in-law, sister-in-law, stepparent, and grandchild (7/1/73).

Insurance

raise lifetime maximum medical benefits from $100,000 to $250,000 (7/1/73);

expand dental coverage to include gingival curretage (7/1/74);

* * *

Income Extension Aid

can be used to supplement unemployment compensa-

tion in event of layoff to bring total IEA and UC to 50% of normal weekly pay (7/1/73);

special continued aid to older employees (55 to 62) with 10 years of service affected by plant closings (7/1/74);

life and medical insurance continued for one year instead of three months in plant closings (7/1/74).

Military Pay Differential

unused summer encampment time can be used to cover weekend duty (7/1/73);

pay for holiday which occurs during military encampment period (7/1/73);

use Federal fiscal year for annual encampment differential (7/1/73).

* * *

Jury Duty

payment for a holiday that falls during jury duty (7/1/73).

Savings and Security Program (1/1/76)

educational withdrawals – expand definition of "child" to include child living in home of employee;

educational withdrawals – include schools for handicapped children;

optional additional unmatched savings up to 3% more (i.e. 3% beyond the 6% or 7% present matched maximums);

Payroll Deduction Savings (the individual's own savings) may be put into Retirement Option – as well as the Company's Matching Payment;

* * *

Income Extension Aid

ARTICLE XXII – IUE AGREEMENT

(Weekly Payment Option – Supplementing Unemployment Compensation to 50% of Pay)

Delete Subsection (3) (1) (a) covering weekly payments after exhaustion of unemployment compensation and substitute the following:

"(a) The employee, while on layoff from the Company and so long as he is unemployed, may elect to receive a weekly payment from the Income Extension Aid payable to him, in such amounts and upon such conditions as set forth in this subsection. Payment may begin only after a one week waiting period following the commencement of layoff.

Prior to the exhaustion of his entitlements to federal and state unemployment compensation benefits, the weekly payment shall be in that amount (if any) which, when added to the total federal and state unemployment compensation benefits received for that week, equals one-half of his weekly pay as defined in Section 2, provided however, that payment shall be made only if the employee has applied for and received unemployment compensation benefits for that week and only if he has provided the Company with satisfactory proof of the total of such benefits received for the week.

After exhaustion of his entitlement to federal and state unemployment compensation benefits, the weekly payment shall be in that amount which equals one-half of his weekly pay as defined in Section 2.

* * *

Modify Article XXII, Section 4 to add (5) effective July 1, 1974, to read:

(5) "In lieu of any other benefits under this Section, an employee whose employment is terminated because of a plant closing and who was age 55 or more at the time of such plant closing and had at least 10 years continuous service at such time, may elect to receive, no later than the date of the plant closing, a monthly Special Continued Income Extension Aid benefit.

* * *

SICK PAY

ARTICLE XXVII

1. An hourly employee with one or more years of continuous service, absent because of (a) personal business, (b)* a temporary layoff as a result of fire, snow storm, power failure or physical inventory, or (c) personal illness for which weekly disability benefits are not payable under the General Electric Insurance Plan, or under Workmen's Compensation, will, with the Manager's approval, receive Sick Pay for each absence of a half day or longer, up to the number of days applicable in accordance with the following schedule:

Continuous Service	Maximum Days of Sick Pay for Each Calendar Year
1 through 4 years	1 day (effective 7/1/73)
1 through 4 years	1 day (effective 1/1/74)
5 through 9 years	2 days
10 through 14 years	3 days
15 through 24 years	4 days
25 years and over	5 days

2. *Accumulation of Sick Pay:**

An employee who has any unused Sick Pay remaining at the end of a calendar year will have such unused Sick Pay, up to a maximum of ten (10) days, carried forward to the following calendar year for use in the event of approved absences.

APPENDIX E

June 6, 1973

Mr. John H. Shambo
GE-IUE Conference Board
15 East 41 Street
New York, New York 10017

Dear Mr. Shambo:

In compliance with the Union's request, the Company agrees to indemnify the Union against any liability that may arise from the application of that part of the 1970-1973 and 1973-1976 GE-IUE Pension and Insurance Agreements which excludes absences due to pregnancy or resulting childbirth or to complications in connection therewith from benefits under weekly sickness and accident insurance.

Very truly yours,

John R. Baldwin

AGREED TO

PLAINTIFFS' EXHIBIT NO. 103

Letter GE to IUE dated June 6, 1973, agreeing to indemnify IUE

(Plaintiffs' Exhibit No. 103 is Appendix E to the 1973-1976 GE-IUE Settlement Agreement which is Plaintiffs' Exhibit No. 102 and is printed as part of that exhibit at p. *supra*.